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PSYCHOSOCIAL AND MENTAL HEALTH ASPECTS OF WOMEN'S HEALTH

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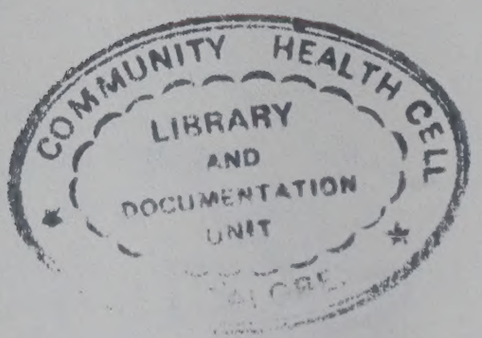

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PREFACE

Women are drawers of water, hewers of wood, labourers, preparers of food, bearers of children, educators, health care providers, producers, and decision-makers. Although they are central to caring for families and communities, to production and reproduction, they are accorded unequal status. Throughout the world they are overworked and undervalued. Their subordination makes it more difficult for them to cope with the many demands made upon them whether of a physical, social or emotional nature. Women are more vulnerable than men to sex exploitation and violence, to poverty and malnutrition, to environmental degradation, to chronic diseases which are often exacerbated by pregnancy and lactation, and to the debilitating effects of harmful traditional practices.

There is, however, a growing recognition that the stresses imposed on women affect their physical, emotional and mental well-being. Epidemiologic evidence is accumulating that links mental disorders with alienation, powerlessness and poverty, conditions most frequently experienced by women. Significant changes are taking place in beliefs and expectations about women's roles and identities in the context of community, family and work. Increasingly, attempts are made to define, understand and explain the female experience. Women's groups around the world are taking the issue into their own hands and searching for their own culturally appropriate solutions to the issue of women's mental health.

This document is the first in a series jointly produced by WHO's Division of Family Health and the Division of Mental Health around the general theme of women and mental health. The aim of the series is to create a forum to debate issues related to women's mental health and to their contribution to mental health care. This debate will contribute to the general reappraisal of women's health problems, giving along overdue recognition to their strength and steadfastness in coping with the myriad problems that assail them, and pointing out future directions for research and action to address women's needs.

The Division of Family Health is proud to be associated with the development of this document together with colleagues in the Division of Mental Health and will continue to strive to improve the health and well-being of the world's women.

by Director, Division of Family Health

It gives me great pleasure to introduce the first issue of a series of publications dealing with women and mental health. The need for an adequate review of knowledge in this area has been repeatedly stressed. Its availability should facilitate and stimulate action programmes. The volume prepared by Dr Dennerstein and her colleagues springs from a joint initiative by the Maternal Health and Safe Motherhood Programme and the Division of Mental Health. We hope that the production of other volumes will also involve our colleagues in the Division of Family Health and in other Divisions of WHO.

Several among these are already prepared. The second issue prepared in consultation with AMRO will present the bibliography of publications dealing with women and mental health and include publications which appeared in the Spanish and Portuguese languages in Latin American countries.

A third issue will present the situation concerning mental health and women in Spain. It was prepared by members of the WHO Collaborating Centre for Research and Training in Spain. It is expected that other requests describing the situation in Japan, Brazil and Italy will be prepared by collaborating centres in those countries.

The authors of the current volume have every reason to be proud of their work. They have produced an excellent appraisal of the situation concerning mental health and psychosocial aspects of women's health. Their review is based on literature in English and it deals mainly with developed countries. This, however, is a logical consequence of scarcity in languages other than English.

We are hoping that this series will stimulate work in countries and that it will help to draw attention to the importance of promoting mental health in women worldwide.

by Director, Division of Mental Health

1. HEALTH, WOMEN'S HEALTH AND MENTAL HEALTH CONCEPTS

Health is a relative state of existence, multidimensional and specific for each individual. In 1946 the World Health Organization defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". On 12 September 1978 the Alma Ata Declaration reaffirmed this definition and outlined a fundamental health strategy of health promotion and of preventive health services. The Second International Conference on Health Promotion held in Adelaide in 1988 identified "Supporting the Health of Women" in the recommendations of four action areas. The issue of "women's health" as a separate field has emerged relatively recently. Historically the health needs of women were recognized largely in relation to women's reproductive functioning as in obstetrics and gynaecology, and family planning. There has been general recognition that although women live longer than men in most of the developed world, women suffer from more acute and chronic symptoms and use health services more frequently. A major health problem area for women is that of mental health. Mental cannot be separated from total health. The dichotomy between body and mind is seen as a product of Western scientific thinking.

Four concepts of normality in mental health are provided by Offer and Sabshin (1984). The first perspective is that of normality as health, a traditional medical-psychiatric approach which focusses on defining pathology. Thus, normality is the absence of pathology. The second perspective is that of normality as utopia or the ideal. This perspective is propounded by psychoanalytic and humanistic theorists who define normality as ideal functioning or self-actualisation. Critics of this approach comment that ideal functioning is seldom realized. Further, in other cultures such as that of the New Zealand Maori, this concentration on the individual is considered the antithesis of mental health. Interdependence rather than independence is valued. The third perspective is that of normality as "average". This perspective is employed by sociologists and is based on the normal distribution with the middle range seen as normal and both extremes as deviant. Thus, normal may not mean asymptomatic. The fourth perspective is that of normality as transactional systems. Normal behaviour is the end result of interacting systems which change over time as a function of development and the type of environment.

This transactional approach is further developed in the Canadian Report : Mental Health for all Canadians (1988). This report utilizes the World Health Organization's description of mental life as "inner experience linked to interpersonal group experience" (World Health Organization Report, 1981). Mental life thus combines together experience of three kinds:

cognitive experiences (perceptions, thinking processes); affective experiences (emotions, moods, feelings); and relational experiences (the way in which people interact with each other and the environment). Increasing recognition of the importance of external forces such associal and economic factorrelationships, physical and organisational environments have led to a broader concept of mental health. Instead of mental health consisting of the individual's characteristics it becomes a resource enabling an individual to interact with the group and opportunities and influences in the environment. The definition developed therefore reflects values and goals of the desired society: "**Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality".**

This definition does not define mental health in the terms of mental disorder, nor does it imply that mental health and mental disorder are opposite poles on a single continuum. Mental disorders are but one of a number of possible obstacles to the individual's utilisation of inner strengths and resources. Other obstacles may be physical illness, poverty, or discriminatory social attitudes, all of which more commonly affect women. Mental disorder may be defined as a recognized medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities. Mental disorders result from biological, developmental or psychosocial factors. The opposite of mental disorder would be a complete absence of symptoms. A mental health continuum on the other hand would have two poles of optimal mental health and poor mental health. Optimal mental health would imply that individual, group and environmental factors work together effectively ensuring: subjective well-being, optimal development and use of mental abilities, and achievement of goals consistent with justice and equality. Minimal mental health results from conflict between individual, group and environmental factors producing subjective distress, impairment or underdevelopment of mental abilities, failure to achieve goals, destructivebehaviours and entrenchment of inequities. This definition offers hope for those who suffer from chronic mental disorders, a broader range of strategies to address mental health goals and makes unnecessary the need to describe goals in psychiatric terms. Further it acknowledges that the distribution of power among individuals, groups and their environments is a crucial determinant of mental health.

The long and arduous struggle for women's rights, for equality with men in political, economic, social, cultural and civil rights is described by Aldaba-Lim (1991). In 1979 the United Nations

General Assembly adopted the 30-article Convention on the Elimination of AllForms of Discrimination Against Women. By April 1991, 104 member states had ratified the Convention. Nevertheless, a number of countries including India, Pakistan and the USA had not yet ratified the convention. There remains a wide gap between reality and plans. At least 444 million Asian women are illiterate, with rural women at the bottom and urban males at the top of the literacy pyramid. Some villages have no literate women. The proportion of women as illiterates has increased in the last 25 years. Although there have been some signs of progress, women's development is lagging behind in many countries. The lessons of the UN Decade for Women is, "If the world is going to change for women, women must change it"

The last decades have seen increasing recognition of the pervasive and destructive effects of gender inequalities and the stresses that differentially affect women by virtue of their unequal social status especially in their family roles. Circumstances and conditions that society accepts as normal or ordinary often lead to mental health problems in women. Women face dilemmas and conflicts in the contexts of marriage, family relationships, reproduction, childrearing, divorce, aging, education, and work. Stresses that have more impact on women and may contribute to a higher risk for depression include : physical and sexual abuse; sexual harassment; sex discrimination; unwanted pregnancy; divorce; poverty and powerlessness. Epidemiological data link mental disorder with alienation, powerlessness, and poverty, conditions more commonly experienced by women (Russo, 1985).

Theories and Therapists

Significant changes have taken place in our beliefs and expectations about women's roles and identities in the contexts of work, family and community over the last decades. During the same time period there has been an explosion of knowledge which signifies the attempt to understand and explain the female experience. This new scholarship has identified sex bias in psychological theories and methods.

Webster and Ipema (1986) illustrate how the "world view" taken by a therapist will affect what is defined as a problem, what is seen as appropriate intervention and what constitutes success when evaluating an outcome. A historical look at theories and philosophies illustrates how powerful they are in determining how problems are interpreted. During the middle ages, signs of dementia were treated by skull trepidation, to release the evil spirits.During the Renaissance it was believed that any woman who claimed to have power

to heal was a witch who could be cured only by torture or death. In the last century recalcitrant or wilfulwomen were treated by oophorectomy. Showalter (1987) described how Darwinian ideas led to the view that biology determined destiny "there is sex in mind as well as in body". Female physiology marked women "for every different offices in life from those of men". Theories of sex differences were elaborated into highly prescriptive traditional sex-roles and used to control female behaviour. Consequently women were viewed as domestic and maternal. Medical ideology fostered the view that a woman's biological system predisposed her to ill-health and failure. In short, women were viewed as inherently sick, predisposed by their constitutions. Hygiene manuals preached a cause-effect relationship between female sexual transgression and ill-health reinforcing the connection between women's social role and her health status. The two major feminist texts (Chesler's Women and Madness", 1972 & Showalter's "Women, Madness and English Culture, 1830 - 1980", 1987) have highlighted the equivalence of "madness" and "femininity", and described fashions in the presentation of women's symptoms and in the (usually) male medical response. The concept of the "hysterical female" was born. Women were repeatedly diagnosed and treated for what feminist writers viewed as culturally determined behaviour patterns women used to deal with the situational anxieties created by their restricted social life.

Plath once remarked that as a woman you are dammed anyway; if you are normal you are mad by implication and if you are abnormal you are mad by definition (Calvert, 1979).

The Freudian view of women as passive, inferior and receptive has profoundly influenced all successive theories. Some theories, such as behaviourism, seemed to ignore women altogether. Women and women's role is discussed by the learned helplessness theory of depression which links depression to low self-esteem and powerlessness.Rigidity towards sex differences and gender-roles persisted into the late 1970s. Evidence for the persistence of sex-role stereotyping in health care is found in studies such as that of Broverman et al (1970). This study found that when considering men and women, clinicians maintained parallel distinctions in their concepts of what behaviourally is healthy or pathological. A double standard of mental health existed. A healthy woman was seen as having traits which differed from those of mentally healthy men or healthy human beings. This placed women in a double-bind as either rejecting feminine behaviour or being feminine at the cost of being a healthy human being. Others suggest that the amount of gender-related bias among experienced practitioners is comparatively small. Nevertheless the documented experience indicates a need for health care practitioners, particularly those in the area of mental health where subjective judgements are commonplace and there is the exercise of power over the lives of others, to be constantly aware of possible sex discrimination in providing service.

Therapy is criticized for attempting to fit women back into the situation in which they became mentally ill, and for failing to look at the necessity for social change. Sex-role stereotyping has limited the roles for women and necessitated greater role adjustments than for men. Criticisms of psychology documented by Webster (1988) include the potential for finding individual pathology and "treating it" in lieu of identifying the social causes of the problems and addressing them. Other criticisms pertain to the problems of subjectivity, and the narrowness of focus. Therapy may distort women's experiences and contribute to women's oppression. Of special concern is the problem of sexual abuse of clients by psychotherapy process. Women's differential rates of depression associated with marriage, with having children, and with work outside the home all put into question the wisdom of fostering women's traditional roles.

The need for new ways to understand women and to help them deal more effectively with problems unique to them, as well as problems which may affect women differently has led to new approaches to therapy for women, such as consciousness raising groups. Differentiation was made between therapy which is non-sexist (attempts to avoid sex-role stereotyping which discriminates against either sex) and therapy which is feminist (goes further and questions the power relationships inherent in any therapy process and calls for new ways to provide an egalitarian experience in therapy which might facilitate learning about women's experiences, rather than telling women what their experiences are or should be). Feminists have made a large impact on the mental health system in their campaign against violence against women and development of alternative models of service such as rape crisis centres and refuges for battered women. New attitudes and knowledge from feminist critiques have helped develop preventative programs and led to legislative change. Examples of the contribution made by feminists include the feminist analysis of eating disorders which views these problems as occurring in societies which have limiting sex stereotypes and which promote a body image ideal that is impossible for most women to achieve. Thus more than 90% of those who suffer from eating disorders are women. Where women are a distinct minority and services cater largely for men, feminist energy has gone into the development of women-oriented services, such as special alcohol services. A major area requiring further attention is the position of women in psychiatric institutions which may include sexism, neglect and trauma as well as sexual abuse.

Today many developmental and psychological theories still present the male experience as normative and ignore or negatively evaluate women's differences in relation to these norms. Consideration of the female experience and its context is essential to developing better theories, and in providing relevant and empowering strategies (O' Rourke, 1984).

Current research together with social change will help in producing a new conception of women. Differences between men and women do not mean that one is weaker than the other, rather there is a need to seek explanations for differences in order to provide a higher standard of health for men and women (O' Rourke, 1984).

2. MEASUREMENT OF OUTCOMES

Most health measures focus on physical and psychological ill-health. Examples include mortality and morbidity measures. Well-being measures will become increasingly important as health services shift emphasis from the provision of curative services to the prevention of ill-health (Kilgour, 1991) and focus on health promotion and quality of life. Health behaviours are activities engaged in to promote or protect one's health, and include breast examination, cervical cytology, medication, diet change. Self-perceived health asks the individual to comparatively rate his or her health as worse, the same or better than others her age. Self-perception has been shown to be a significant indicant of health (Mossey & Shapiro, 1982).

Murchie (1984) in a New Zealand study compared Maori women who said their general health was good with those who said their health was "fair" or "poor". This study used measures of well-being, and ill-health and derived a profile of factors associated with good health among Maori women. A woman in good health was twice as likely to say she has no major worries; 1.5 times as likely to say she has no frustration over her work situation; 3 times as likely to be not at home with dependents; twice as likely to have no worries about her children; 1.5 times as likely to be not primarily in home care.

Symptom checklists provide estimates of distress and demoralisation, but do not permit classification of subjects into discrete disease categories and the relationship between impairment ratings and specific diagnoses is not strong. Depressive symptoms are the most common type of manifestation of psychological distress and are common to many and varied types of psychiatric disorders.

A large survey was carried out in the Otago region in New Zealand and focused on women's mental health (Walton et al, 1990). The outcome measure was the General Health Questionnaire (GHQ) which measures psychiatric symptomatology. This study illustrates the way in which physical and social factors may act to initiate or perpetuate mental ill-health. Poor physical health and major marital problems were related to becoming mentally ill. Other

factors which correlated with psychiatric morbidity were: quality of social networks; difficultieswith alcohol; childhood sexual abuse; low socioeconomic status; and adult experiences of sexual and physical abuse (Romans-Clarkson et al, 1990). Of those who became ill, 2/3 had recovered within one year. All of the women who continued to be ill had suffered a major financial crisis (Walton et al, 1990).

A United Kingdom general practice survey of women aged between 20 and 59 years found similar results (Ballinger & Smith, 1985). Separated and divorced women had the highest risk of psychiatric morbidity and single women had the lowest risk. Women with three or more children had higher GHQ scores. High scores on the GHQ were associated with interpersonal relationship problems with parents or husband, marital status, numbers of children, social class, and gynaecological problems such as painful, heavy or irregular periods.

Gath and Iles (1990) highlight the need to distinguish between depressed mood (feelings of sadness familiar to everyone) and depressive disorder (a syndrome which is less common but far more serious). The features of depressive disorder include depressed mood, loss of interest, energy, and enjoyment, poor concentration, gloomy thoughts of guilt, worthlessness, hopelessness or suicide, disturbances of appetite, weight, sleep, and sex drive and slow speech or movement.

LaDue in an unpublished paper noted that all diagnostic criteria and assessment methods rest on theoretical constructs about human behaviour, normality and pathology. For example it is commonly assumed that auditory hallucinations and disordered thoughts coupled with social withdrawal are symptomatic of schizophrenia. Traditional practices of certain ethnic groups may mean that symptoms reflect religious practices and are part of a healing process rather than increasing pathology. The use of drugs, trance states, withdrawal from one's community and other "abnormal" behaviours need to be viewed within a cultural, religious context before being deemed to be deviant and/or detrimental. There appear to be few universals as regards pathological behaviours with many groups having syndromes specific to only that group. Thus standard assessment and diagnostic tests may not be appropriate for minority groups and other cultures.

3. GENDER DIFFERENCES IN MENTAL (ILL-) HEALTH

A range of studies indicate that women are disproportionately affected by mental health problems and that their vulnerability is closely associated with marital status, work and roles in society. The 1983 Australian Health Survey found that 357,000 females and 197,000 males reported mental health problems.

Russo (1990) reports that epidemiological community-based studies found that for the 15 diagnostic groups studied there were substantial gender differences in prevalence rates of lifetime diagnoses. Women predominate in major depression, agoraphobia, and simple phobia whereas men predominate in antisocial personality and alcohol abuse/dependency. Women were more likely than men to have received a diagnosis of dysthymia, obsessive-compulsive disorder, somatization disorder, and panic disorder. No gender differences in manic episode or cognitive impairment were apparent. It should be noted that there is controversy about the inclusion of alcohol disorders (as well as drug and personality disorders) in the definition of mental disorder as these disorders may not cause personal distress or mental disorganisation. There were also marked gender differences evident in the utilisation of mental health services in the USA. Gender differences varied by martial status and race/ethnicity and cannot be explained by biomedical models. Never married and separated/divorced men have higher overall admission rates to mental health facilities than women in the same marital status categories. In contrast, married women have higher admission rates than married men. However this does not hold for all diagnoses. These findings emphasize the importance of understanding complex relationships among gender, ethnicity, sex-roles, and mental health. Research has rarely considered such joint effects.

Social factors may aid women's adjustments to certain disorders. For example a different pattern but not prevalence level exists for schizophrenia, where women appear to have a later onset by 4-6 years, shorter and fewer hospitalisations, and better prognosis and greater expectations, more social support and greater societal (and parental) tolerance of women's support to remain at home. Social factors contributing may include lessened social role expectations, more social support and greaater societal (and paarental) tolerance of women's schizophrenic symptoms (Report of the Health Care Committee, 1991).Gove and Tudor (1973) had earlier argued that because of the roles women occupy in Western society, women are more likely than men to have emotional problems. Major reasons proposed were that : 1) men have two sources of gratification - work and family, whereas women have only one-family; 2) raising children and keeping house is frustrating; 3) the role of housewife is

relatively unstructured and invisible; 4) when a married woman works she is in a less satisfactory position than the married male; 5) expectations confronting women are unclear and diffuse. These authors noted that both community-based and treatment studies clearly showed that more women than men have mental ill-health problems. However this applies to married women and married men. Amongst the single, within each category men were more likely to be mentally ill. Prior to World War II more studies show a higher rate of mental illness for men than for women indicating that social change has adversely affected women. Also in communities undergoing economic depression, there was a higher incidence of mental illness and the rates were higher in men than in women. In contrast in an integrated French Arcadian village - traditional, family orientated and culturally isolated, there were lower overall rates of mental illness and women had lower rates than men.

Ibrahim (1980) in an earlier review of the relationship between marital status and mental health found that married women experience higher rates of mental disorders than married men, although single women exhibit rates of mental disorders similar to or even lower than the rates shown for single men. Married individuals of both sexes experience better physical health than the unmarried. It would appear that being married as compared with being single is generally associated with better physical health for both men and women, but not associated with better mental health for women unless they are gainfully employed. Such employment under certain circumstances may have detrimental consequences.

Ross et al (1983) tested the hypothesis that in societies which value the family and the women's role in the home, psychological distress levels of married men and women will be more similar. These authors utilized a questionnaire to compare an Anglo-American community with a Mexican community. The gap in psychological distress levels of married men and women was less in Mexican culture than in Anglo culture. However, education and the wife's participation in the labour force affect marital satisfaction which in turn affects the level of psychological distress. Education increases marital satisfaction whereas paid employment decreases it. Wife's employment decreases her psychological distress directly in both cultures. Parry and Shapiro (1986) found that in the case of working class women, working outside the home was associated with less depression where there was good social support, but more depression where there was not good support..

Russo (1990) in her review noted that parenthood, particularly when children are young, increases the symptoms of psychological distress for women whether or not they work outside the home and these symptoms appear to increase with the number of children living in the home. Whether or not employment brings mental health costs or benefits to women

depends substantially on husband's attitudes, and satisfaction with child care. For employed mothers, if child care was accessible and husbands shared in it, depression rates were low. In contrast, employed mothers without accessible child care and with sole responsibility for child care had extremely high depression levels. For non-employed wives, children increased depression levels. Rosenfield (1989) proposed that role overload causes greater symptoms for the same reasons as low power: through lowering an individual's sense of personal control. Thus employment may trade one source of low control for another. Personal control may also explain differences in symptomatology by social class.

Depression

Depression, the most prevalent psychiatric condition, is the most frequently encountered women/s health problem in many Western countries. Depression may vary imperceptibly through subclinical distress to a normal mood which is part of universal human experience. Defining threshold for disorder and separating this from normal experience have been important. Community prevalence studies indicate that about 5% of the population satisfy the criteria of the PSE (Present State Examination) or the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM 3) for psychiatric depression in a six month period. Sex ratios in treated cases of depression in Western cultures show a 2:1 predominance of women to men (Weissman & Klerman, 1977). Jorm (1987) from a quantative synthesis of published prevalence data shows that the sex differences in depression for females are age-specific, and also a function of social situations. In children and the very old there is little sex difference, but in the years 15 - 50 depression is more prevalent in women.The following review of gender differences in depression is abstracted from Paykel (1991) who offers the following explanations and evidence :

1. **Women may more often seek help for depression which both sexes suffer from equally.**

Most studies show that women attend doctors more than do men. Kessler et al(1981) analysed data for psychiatric symptoms from four large-scale community surveys.. Women reported more psychiatric distress but also showed a greater readiness to consult at the same level of morbidity; this appeared to be due to a greater readiness to translate non-specific feelings of distress into a recognition that they had an emotional problem. However for specific depressive symptoms and anxiety the female predominance is present in community surveys to an equal or greater extent. Studies using questionnaires to measure depressive symptoms give point prevalence rates varying form 13%-20%. The mean sex ratio was 1.9,

virtually the same as the treatment studies. Studies which employ psychiatric criteria give lower total rates (6 month prevalence 3.0%-7.4%), however the average sex ratio remains at 2.0. The female predominance of depression is therefore not an artifact of treatment seeking.

2. Given that there is a difference does it reflect biological factors such as chromoso mal factors or female sex harmones?

There is clear evidence from twin studies of a genetic element in affective disorders. This is most marked for bipolar disorder, but also significant for unipolar psychotic depression. For unipolar neurotic depression twin studies are less conclusive. There is a familial element but it is not clear whether this is genetic or environmental. There is some evidence in some families of X-linkage in bipolar disorders. However the sex ratio for bipolar disorders is approximately equal. There is no good evidence for X-linkage in unipolar disorders.

Other biological explanations centre on the different hormonal background for men and women. Indirect evidence can be gleaned frorn hormone-related phenomena. Premenstrual tension includes depressive mood changes but has not been linked to specific hormone changes.Oral contraceptive studies are not conclusive and suggest that any clinical effect is small. Childbirth is associated with an increase in onsets of psychoses and hospital admissions and is a time of massive hormonal change. Increased onset of bipolar disorder occurs at this time. Recent evidence is that postpartum psychoses are not related to recent life stress making biological (and hormonal) explanations more plausible. Milder postpartum depression at the sub-clinical or general practice level is common.

Gater et al (1989) studied first admission rates for psychosis in the North West region of England. Rates were higher for women. The excess was accounted for by women who had one or more children. The excess was related to parity rather than marital status. Bebbington et al (1991) using data for prevalence of minor affective illness obtained similar findings, although it was not clear whether having children or marital status was responsible. These findings of a peak in depression in young mothers in developed Western societies could reflect families that are nuclear and geographically mobile, lack of extended family support and the woman's dependence on the quality of her relationship with her partner.

Another phase in which women experience great hormonal change occurs at menopause. However there is no peak in major depressive disorder at the biological menopause.

3. Another explanation is based on the social effects of life stress, of social vulnera bility factors and absence of support, and of women's role in society more widely.

There is now a large and conclusive volume of research showing that clinical depressions are preceded by elevated rates of the more threatening classes of life events. Women do not experience more life events than men. Men and women rate the stressfulness of life events similarly. Nevertheless community studies suggest that women react with higher symptom intensities to the same stress. Thus there seems to be more vulnerability to the effects of life events. Social vulnerability studies have particularly emphasized social support, implicating most clearly the absence of a confidant and less consistently, the presence of young children in the home, lower social class, not working outside the home, and early loss of mother. For work outside the home there has been less replication and complex effects (see previous discussion). Other hypotheses outlined earlier, centre on the disadvantage of women's roles in society with low social status accorded to homemakers, and social discrimination leading to low aspirations, dependency, low self-esteem.

4. A final explanation for differences in depression rates may reflect a difference in acknowledgment and direction of distress. Alcoholism is more common in men.

Winokur (1979) described depressive spectrum disease in which women tend to have depression, while male family members have alcoholism and antisocial personality. Men may direct their distress in different directions. Men have a higher rate of suicide although more women attempt suicide. Briscoe (1982) found women more willing to acknowledge feelings, both positive and negative.

Studies of other cultures are informative. The Old Order Amish of Pennsylvania, a religious group with strong prohibitions on drink and antisocial behaviour have high rates of affective disorder. Unipolar and bipolar depressions show an approximately equal sex incidence. Weissman & Klerman (1977) reviewed treatment studies from Guinea, India and Papua which show a reversal of the Western sex ratio to a male predominance. However women may not have had equal access to help seeking. Community-based studies which are culturally appropriate are needed.

Recent Western community based studies repeated 10 to 20 years apart show a trend for the sex ratios to equlize. This may reflect societal changes with less gender role differentiation, which may change the acknoledgement and the social stress. Sex ratios for depression appear to be more equal in university students and no major sex differences were found in

certain occupational groups. Klerman & Weissman (1989) suggest the narrowing in the gender differential may be due to a greater increase in risk among young men. These trends were evident in studies from the USA, Sweden, Germany, Canada, New Zealand but not in Korea, Puerto Rico and for Mexican Americans living in the USA. This may reflect changes in social factors such as changing family structures and social roles.

4. ETHICAL ISSUES IN WOMEN'S MENTAL HEALTH

Special ethical issues of concern to women were reviewed by Nadelson (1991). Some of these issues have reflected the historical development of the health care delivery system as paternalistic and hierarchically based, with the doctor dominating the system. The doctor was usually male, informed, authoritative and protective and this conformed with traditional social roles of men and women. Policies and priorities have often been based on this perspective particularly related to reproduction. An example of paternalism quoted by Nadelson was the USA decision to prohibit the use of RU486, an abortifacient with other potential uses. Those most affected were not involved in the decision-making process. Interestingly, there has been an increase in paternalism in the health care systems of the USA and other countries at the same time as there has been a decrease in paternalism in the individual doctor-patient relationship with decision-making shifted from the doctor to the bureaucracies. Documentation of gender bias in medical care and in research has led to the creation of an Office of Research on Women's Health by the US Government and to proposed legislative changes.

Ethical issues also relate to informed consent, the giving of which implies understanding and assent. Patients may not comprehend because of educational level, mental illness and other factors.

The special characteristics of women's reproductive roles lead to specific ethical considerations. Since decisions about childbearing, contraception, abortion, sterilisation and surgery involving reproductive organs have profound social consequences, the autonomy of women in deciding these questions is often challenged. In most cultures women have not been in a position to achieve their own goals if they are distinct from those of their own family and society. Decisions may reflect the personal, cultural or religious values of the patient, doctor, the family or society. Examples of ethical dilemmas include those arising from genetic testing in pregnancy and use of this technique for sex selection, and the use of reproductive technologies such as in vitro-fertilisation, artificial insemination and surrogate motherhood.

These techniques raise the question of the rights of biological versus social parents, the rights of children born from these procedures, and the nature of informed consent by all parties. Also these techniques may be reserved for specific types of individuals or situations (e.g. heterosexual couples). Substance abuse during pregnancy has also caused controversy, pitting the autonomy of the mother against the needs of the fetus.A number of clinical studies have found that sexual relationships between carers and patients are harmful and may have acute as well as long term consequences. In addition to the shame, guilt and mistrust they experience, these patients have been reported to suffer from post-traumatic stress disorder, anxiety and depressive disorders, sexual symptoms, sleep disorders and are at higher risk for substance abuse. Most cases of reported incidents of sexual misconduct in the USA involve male doctors and female patients (88%).

For society the changing roles of women and the emergence of new reproductive and other technologies have raised questions with profound ethical implications. Culturally determined values and ethical values may clash (Nadelson, 1991).

5. PSYCHOSOCIAL DETERMINANTS OF WOMEN'S MENTAL HEALTH

A significant change of perspective regarding women's mental health was signalled by the priority areas outlined in both the National Institute of Mental Health's document (Eichler & Parron 1987) in the United States and the National Women's Health Policy (Commonwealth Department of Community Services and Health 1989) in Australia.

Both reports recognized the inadequacy of existing scientific knowledge relating to gender differences in mental disorder and its treatment. The five areas requiring research according to the US report were the diagnosis and treatment of mental disorder, mental health issues for older women, violence against women, multiple roles and poverty. Importantly, three of these five areas, namely violence, multiple roles and poverty, focus specifically on the way in which women's actual experience and their subordinate position in society contribute to their mental health. Further, the first two areas, diagnosis and treatment of mental disorder and mental health issues for older women can also be seen to be directly contingent on sociocultural factors.

Research undertaken in the 1970s underlined the way in which gender stereotypes and views on gender appropriate behaviour held by psychiatrists and psychologists could

influence the diagnosis and treatment of women patients (Broverman et al, 1970; Kaplan, 1979; Billingsley, 1977). While this early work demonstrated that mental health professionals upheld genderstereotypes and attributed externally imposed societal limitations to intrapsychic conflicts, research undertaken since 1985 suggests clinicians no longer hold significantly different mental health expectations for male and female patients (Phillips & Gilroy, 1985; Poole & Tapley, 1988; Kaplan et al, 1990).

The seven priority areas delineated by the Australian policy were reproductive health and sexuality; health of aging women; emotional and mental health; violence against women; occupational health and safety; health needs of women as carers and the health effects of sex role stereotyping on women. The Australian policy rests on two stated perspectives. First, that provided by the World Health Organization's' Health for All by the Year 2000' initiative with its emphasis on primary health care and social justice and second, a 'social health' perspective which recognizes the interaction between social and economic factors and health.

However, this sociocultural perspective is relatively new in research on women's mental health. Until recently, much of the therapeutic and research endeavour in this area, sought to establish an intrinsic biological, hormonal or endogenous explanation for psychological distress, illness and disorder in women. A large research literature exists, for example, on the relationship between women's reproductive processes, from menarche to menopause, and their mental health and well-being. In reviewing this literature, Gitlin and Pasnau (1989) consider the evidence relating to four psychiatric syndromes which have been specifically linked to women's reproductive functions, namely postpartum depression, premenstrual syndrome, post-hysterectomy depression and involutional melancholia. They conclude postpartum depression comprises three separate syndromes; the effective study of premenstrual syndrome is dependent on improved methodologies and there is no evidence for post-hysterectomy depression and involutional melancholia. They argue our current level of understanding is poor as it rests on unwarranted assumptions and conclusions based on old, poorly conducted studies and a mixture of myths and culturally biased attitudes towards women. These attitudes have biased supposedly objective observations and implied aetiological links, with the result that observations more often and more accurately reflect the psychology of the observer, usually a man, than the observed. Acquiring knowledge, they conclude, will depend on designing better quality studies using data based research. Progress in this direction is still in its early stages.

While it is not disputed that the frequencies and patterns of mental disorder do differ for men

and women, as found by the NIMH Epidemiological Catchment Area (ECA) Program (Eaton & Kessler 1985) for the fifteen diagnoses studied, the interpretation and explanation of these differences is open to discussion.

Women do predominate in diagnoses of depression, agoraphobia, simple phobia, dysthmia, obsessive compulsive disorder, schizophrenia, somatization disorder, panic disorder and histrionic personality disorder. The question is whether these differences in psychological morbidity are reducible to biologically based differences or whether they are better explained by reference to social role obligations, acquired risks and sociocultural factors in general (Kandrack et al, 1991). Certainly, the assumption that to be biologically female is to be intrinsically at higher risk for certain forms of psychopathology, such as Histrionic Personality Disorder, previously known as Hysterical Personality Disorder, is being increasingly challenged by empirical research. Thus a recent epidemiological study (Nestadt et al, 1990) of almost 3,5000 subjects, carried out in conjunction with the ECA survey in Baltimore, on Histrionic Personality Disorder, found that males and females were equally affected. The population prevalence was 2.1%. The researchers concluded previous studies which reported the disorder was largely confined to women, focused on clinical populations and exhibited significant ascertainment biases relating to help seeking and sick role behaviours.

The historical dominance of an individual, pathologizing approach to women's mental health is in large degree derived from the clinical and theoretical influence of Sigmund Freud's work. The overwhelming emphasis Freud gave to biological over social factors, was influential in bringing about a preoccupation in much subsequent psychological and psychosomatic research, with a search for factors within a woman's own body and/or mind to account exclusively for her mental health. This search for 'within' woman factors was probably bolstered by the radical change in Freud's theorising on the question of childhood sexual abuse.

Initially, Freud hypothesized a clear connection between childhood sexual events and the development of hysteria in adult life. The events which occurred were referred to in such terms as 'rape', 'assault', aggression', 'abuse' and 'seduction'. All but the last of these explicitly acknowledge that violence by an adult has been perpetrated on a child. By his retraction of the early theory and subsequent reliance on the word 'seduction' with its ambiguity and blurring of who is responsible, Freud tended to remove an awareness of violence being perpetrated but involved the child in being a possibly willing and in a sense, an equal participant. In addition, when Freud decided that the reports of abuse he was hearing from his women patients were fantasies rather than facts, the distinction between the two fell away and became unnecessary for therapeutic purposes.

What actually happened to the women as a child in a real world, which Masson (1988) calls 'external truth' or historical truth, with its marked asymmetries of power between children and adults, became ablated in this therapeutic revision. Only what went on within the woman herself, as determined by Freud's own theories of the unconscious, became a suitable object of therapeutic endeavour; nothing external to her could or should be changed, real trauma did not occur.

Masson, in discussing Freud's case history of Dora (Freud, 1905) which marks the change of his theories on the causes of hysteria, says:

'It is his declaration to his colleagues, (Who had given his original theory on trauma an 'icy reception') as if he were telling them: "Look, Dora was suffering from internal fantasies, not external injuries. The source of her illness was internal, not external; fantasy, not reality; libido, not rape"', (p 105)

One of the givens of feminist critiques of knowledge in the social sciences (Harding 1987) is that previous theories have never been constructed by or based on the experiences or ideas of women. Yet the affect of psychoanalytic thinking with its emphasis on internal rather than external reality, suggests that the simple exclusion of women's voices from the theories of social science is not the sole difficulty. Alongside exclusion, there is a problem of distortion when women do not speak for themselves but rather are spoken for though a theoretical model they had no part in devising. In Freudian therapy, it would seem the woman patient and her therapist are in a remarkable relationship to one another. The therapist listens to what the patient is saying, but 'knows' psychoanalytically speaking, that what she says happened did not happen and that what she says she does not want, is, in fact, what she deeply desires.

Thus a double crossover, has to be effected in the correct psychoanalytic translation of the patient's narrative; something which the patient can never properly understand for herself without the aid of her therapist. She is rendered incapable of being a 'knower' or even a reliable observer of her own life; not only does she want what she says she does not want, but what she says happened never occurred. Consequently the true state of her desire is the opposite of what she thinks: unconsciously, she is deeply desirous of something which did not take place and consciously, she is deeply distressed by something which did not occur.

Elaine Showalter (1987) argues that throughout the history of psychiatry men such as Pinel,

Conolly, Charcot, Freud and Laing, have claimed they would free women from the 'chains of their confinement to obtuse and misogynistic medical practice'. However, until women speak for themselves Showalter argues, these 'dramas of liberation become only the opening scenes of the next drama of confinement'. (p250).

So effective was Freud's repudiation of the idea that actual childhood abuse had related to hysteria in adult women that Morrison (1989) in a review of the research literature, found that of the 75 papers published since the 1950s, only two provided any data at all on the patients' childhood sexual histories. One of these (Winokur & Leonard, 1963) did not even inquire about childhood experiences per se but rather reported the adolescent sexual experiences of the women with hysteria, did not differ from the general population as reported by Kinsey in 1953. The second paper (Coryell & Norten, 1981) reported an 18% incidence of childhood sexual abuse in patients with somatization disorder compared with no incidence in patients with primary affective disorders. However, this finding was discounted by the authors in a way which suggests the primacy of Freudian theory over patient perception. They disclaimed their own findings by explaining away the discrepancy between their data and the theory by saying 'questions concerning the validity of (early sexual molestation) are classic.'

Morrison's own research comprised an interview-based study which compared 60 women with somatization disorder and 31 with primary affective disorders, matched for race, age and level of education. He found 35% of women with somatization disorder had been sexually molested as children compared with 13% of the women with affective disorders. He concluded: 'The paucity of research into the sexual backgrounds of women with somatization disorder may stem from the traditional belief that women with hysteria have only imagined early sexual molestation.'

The individual, biological , 'within' woman focus originally emanating from Freud, deflected clinical and therapeutic attention and research endeavour away from a consideration of the actual conditions of women's lives, their social and sex role obligations and position in society and their experiences of physical and sexual violence. All of these factors could be expected, from a social health perspective, to have a bearing on women's mental well-being.

Thus an important effect of the focus on biological, (hormonal/reproductive) within woman factors, was to localize pathology within the individual patient and decontextutalize mental illness and its treatment. By implication, social realities were denied the possibility of making a contribution to mental illness. Alternatively, the individual focus might recognize social and economic contexts, but only as immutable 'givens' in a person's life, to which she must

accommodate rather than attempt to change.

However, while individual approaches to treatment focus on bringing about change within the individual, Kleinman and Cohen (1991) have shown how very powerful messages about appropriate social roles are contained in psychiatric drug advertisements. In a content analysis of drug advertisements which appeared in the American Journal of Psychiatry between 1980 and 1988, they found advertisements aimed at women patients stressed the taking of medication would achieve 'maintainability' and manageability' of the traditional domestic division of labour. While reinforcing the view that women should perform all domestic work, the advertisements conspicuously failed to recognize how inadequate social support, a more equitable division of domestic labour, the absence of social recognition or alternative job opportunities, could cause psychiatric symptoms. Instead, they conveyed the implicit message that 'the problem lies within individual women themselves.' Kleinman and Cohen comment on the specious causal sequence implied in such advertisements which further obscures the impact of social roles and expectations on the development of distress:

If there is a drug which will alleviate their problems, then they must be ill; this logic reveals the extent to which drug advertisements have influenced medical conceptions of health and illness'.

The denial of the social context of women's mental illness in these advertisements cannot be explained away on the grounds that there is no knowledge of the role social context and social support plays in the aetiology of mental illness.

As far back as 1855, there was evidence which suggested adverse social circumstances played an important role in mental illness, with the finding that rates of 'insanity' were proportionately 64 times as high in the 'pauper' as in the 'independent' class (Jarvis, 1971).

More recently, the classic study of Brown and Harris (1978), social Origins of Depression: A study of psychiatric disorder in women, preceded the time span of advertisements included in Kleinman and Cohen's study by two years. Brown and Harris underlined the importance of stressful life events in bringing about depression. Four vulnerability factors were found which increased the chances of a women developing depression in the presence of a stressful life event or difficulty. The factors were : parental loss before 17 years of age - particularly the loss of one's mother before the age of 11, the presence at home of three or more children aged less than 14, a poor, nonconfiding marriage and the lack of full or part-time empolyment. The importance of these factors, especially the quality of a woman's

relationship with her husband, have been confirmed in a number of other studies (Roy, 1978, 1981; Brown & Prudo, 1981; Paykel et al, 1980; Campbell et al, 1983 & Parry & Shapiro, 1986).

The sociocultural conditions of women's lives and their contribution to emotional and mental well-being are now receiving the attention of researchers.

Recent research differs in a number of ways from earlier research. Firstly, it often has an explicit concentration on gender differences which contrasts with the older research on sex differences wherein sex and gender were often confounded. The distinction between the two is crucial, because it acknowledges that gender is socially and culturally constructed while sex is a biological given. Thus while sex is immutable, (surgery apart) the construction of gender may change according to changes in culture and social attitudes.

Secondly, recent research on gender, is usually informed by feminist critiques of social sciences (Keller, 1985; Bleier, 1986; Harding, 1987) and the gendering of knowledge and as such is often powered by very different questions and hypotheses relating to women's social role and experience. It eschews biological reductionism, both as a starting point for research and as a ready source of interpretation of empirical results. This research typically seeks to convey the female experience from a 'woman centred' viewpoint (Lempert, 1986). It investigates rather than perpetuates gender bias in psychological theories and methods andit documents the deleterious effects of gender inequality and sex-role stereotyping in various aspects of women's lives. As such it has led to new ares of psychological research, an increased awareness of and questioning of gender-based assumptions in research and a reconceptualisation of women's psychology and men's psychology, previously equated with psychology in general (Carmen et al, 1981; Gilligan 1982). Before the development of a feminist perspective which provided the methodological tools for applying a gender analysis to psychology, it contained an androcentric bias. Many issues such as male violence against women were not defined as important topics for scientific attention (Walker, 1989).

Evidence bearing on the relationship between the conditions of women's lives and their mental health will now be discussed under two broad headings:

1. The conditions of women's lives.

2. The impact of physical and sexual violence.

5.1 Conditions of Women's Lives : Effects on Mental Health, Poverty, social position and mental health.

A strong, consistent, inverse relationship between socioeconomic status and a variety of mental disorders has been found in epidemiological investigations of the prevalence of psychiatric disorder in community populations since the turn of the century. Neugebauer, Dohrenwend & :Dohrenwend, 1980, in a review of studies to that time, found that psychopathology was at least two and a half times more prevalent in the lowest social class than in the highest. This estimate parallels that found for many physical disorders, where the same relationship between social class and health obtains (Marmot et al, 1987).

Holzer et al, (1986) summed ECA data across all five research sites in the study and found that the six month prevalence of any DSM -III disorder was 2.86 times higher in the lowest socioeconomic status category than in the highest, controlling for age and sex. Dohrenwend (1990) in a more recent review of the evidence provided by studies using the more rigorous and explicit diagnostic criteria of DSM -III RDC or Feighner, found there was still compellingevidence of the relationship of SES and certain psychiatric disorders, namely schizophrenia, major depression, antisocial personality disorders and substance abuse.

Belle (1990) in a review of poverty and women's mental health notes that a great deal of research has been focused on depression because of the high prevalence of depressive symptoms among women compared with men. Two thirds of depressed patients are women and depression is the most commonly encountered women's health problem (Carmen et al, 1981, Benedek, 1981; Lempert 1986).

Amongst the correlates of depression identified in community studies since the 1970s high levels of depressive symptoms were common among women without confidants, child rearing assistance, employment, economic problems and chronic stressful conditions (Brown et al, 1975; Pearlin & Johnson, 1977; Radloff, 1975; Belle, 1982; Makosky, 1982). Kaplan et al (1987) in a longitudinal study of depression found inadequate income was associated with an elevated risk of depressive symptoms over the nine year period of their study. Another study reported that nearly half low income mothers of young children had depressive symptoms and low income, unemployment and single parent status were all associated positively with the extent of depressive symptoms (Hall et al, 1985).

Perhaps the two groups of women most severely affected by poverty and its associated adverse effects on mental health are women heading single parent families and their

children, amongst whom there has been a dramatic increase in numbers and also the numbers living below the poverty line (Belle 1988; Blaxter 1981; Trethewy 1989) and elderly women. Mowbray and Benedek (1988) using US figures have estimated that the numbers of women 65 years and older will double in the next 50 years, the majority of whom will be reliant on Government support. Currently more than a quarter of white women, almost a half of Hispanic women and 60% of black women live below the poverty level (Eichler & Parron, 1987). Further, the care of this increased population, if current trends continue will largely fall on their female relatives, with associated costs to their mental health (Eichler & Parron 1987). Leading mental health problems in the elderly are depression, organic brain syndromes and dementias. A quarter of those over 85 years have Alzheimer's disease or a related condition and most of them are women (Cohen, 1988). The use of psychotropic drugs, often in combination with a variety of other medications, is a particular concern for elderly women.

The relationship between low socioeconomic status and a high prevalence of psychiatric disorders has been subject to two quite different explanations. One, explains the relationship in terms of the greater environmental adversity which accompanies lower socioeconomic status which, in turn, produces high levels of social and personal stress. The other, a more biologically based explanation, is that rates of psychiatric disorders are higher in lower socioeconomic groups because persons with the disorders or with other personal characteristics predisposing towards the disorders are selected down into these groups or fail to rise out of them. Dohrenwend (1990) comments that the issue still remains unresolved. Despite this lack of resolution, publications investigating the relationship between SES and psychiatric disorders have decreased in the last decade, which cannot be attributed to compelling new evidence. Angermeyer and Klusmann (1987) in tracing the shift in social research from an emphasis of societal level analyses of SES to more micro-level, individual based analyses of stress experience, assert there is

> 'a possibility that social class issues may be simply ignored instead of elucidated by the new thrust toward stress research'. (p6)

Dohrenwend (1990) referring to his own, current, epidemiological study in Israel and the ECA collaborative study, (Holzer et al, 1986) the largest ever undertaken in psychiatric epidemiology, notes that for schizophrenia, major depression, and alcohol abuse or dependence there is still a highly significant inverse relationship with SES. He argues that far from the potential of the concept of social class being exhausted, a great deal remains to be done but what is needed is that more theoretically informed analyses of SES based on more sophisticated and relevant measures from disciplines including psychology, genetics and

sociology have to be applied.

One suggestion he makes is that the relationship of SES to psychiatric disorder should be explored within the context of knowledge about how SES relates to various personality characteristics such as locus of control, values and attitudes and various stressful events and situations.

Clearly, there is a need to go beyond the 'facts' of the documented association of SES and mental health, where SES is crudely operationalized into measures of educational level, occupational level and income and ask what the conception of SES means, in terms of theconditions of women's lives, their exposures to stressors and the choices and opportunities, which may or may not be open to them as a result. It is only on the basis of this information that a fruitful enquiry could be made into why there is a higher prevalence of certain mental health disorder such as depression among women and especially among poor women.

Belle, (1990) does, in fact, incorporate this approach into her investigation of the association between poverty and poor mental health in women. Belle asserts that poverty itself imposes a considerable stress on women as individuals and on their families while at the same time is responsible for attacking many potential sources of social support.

Positive correlates of depressive symptoms identified by Belle include and uncertain income, inadequate housing, single parent status, unrelieved child care, lack of college education and unemployment. Paltiel (1987) confirms that there are obstacles, deficits and threats to health inherent in poverty such as the lack of the basic necessities and amenities of life, exposure to dangerous environments, isolation from information and support and an increased incidence of behaviours which pose a risk to health. These 'mal-adaptive' behaviours such as the use of alcohol, tobacco and licit and illicit drugs often represent counterproductive coping behaviours undertaken to provide relief from stressful lives over which the women may have little or no control. Alternate healthy coping behaviours might require the investment of time, energy, knowledge or money beyond the individuals perceived or actual capacity such as psychological counselling, exercise, nutritious food and the uptake of preventive health behaviours. It is also known that poor women use the medical services available less often than their better off counterparts and are less likely to participate in preventive programs (Australian Government Commission of Inquiry into Poverty, 1976).

Chronic life conditions can be even more potent stressors than acute crises Belle (1990) argues. In addition, poor women are disproportionately exposed to crime, violence and

discrimination especially if they belong to minority groups. They experience more frequent, more threatening and more uncontrollable life events than does the general population, including the illness and death of children and the imprisonment of husbands (Brown et al, 1981; Belle 1982; Makosky 1982). While income levels have been shown to predict depressive symptom level, through their link to specific financial problems, parenting problems and child care problems, the linkages between various stressors and supports and depressive symptoms levels can vary with both marital and employment status. Thus role overload and marital difficulties can be more predictive with married women and the size of the social network may be more important with unemployed women (Hall et al, 1985).

Unemployment has also been shown to be a contributing factor in increased rates of suicide among women, as well as men, during the period 1974-1986, when major rises in both unemployment and suicide occurred in many Western nations (Pritchard 1990). Pregnant women and mothers of young children who are unemployed also have higher rates of anxiety and depression than employed women (Brown & Harris, 1978; Najman et al, 1983).

Further, as Belle (1990) points out social networks do not simply function as sources of social support, they can also serve as 'conduits of stress. Thus women in difficult economic circumstances, whose relatives and friends are in the same position and also vulnerable to an increased number of stressful life events, may experience considerable stress 'contagion' (Wilkins, 1974).

Coping with the conditions imposed by poverty can be further constrained by having to be financially dependent on the state through its various bureaucratic institutions. Dealing with each of these for such basic necessities as housing, health, social justice and child welfare, can be time consuming, frustrating, frightening and the dependence created is likely to heighten feelings of powerlessness, lack of autonomy and a sense of worthlessness.

Depression may therefore become an almost unavoidable response to an environment that allows women little control over the most important things in life and little hope that life will improve (Belle, 1982). The use of drugs and alcohol as a means of dealing with life's seemingly intractable problems, briefly referred to here, will be discussed more fully in the section on the consequences of physical and sexual violence.

In addition, homelessness, which has emerged in the USA, United Kingdom and Australia as a major social problem in the last decade has been characterized by both an increasing incidence and decreasing age when first experiencing homelessness. Homelessness is

known to be related to high rates of mental disorder, with up to a third of all homeless people suffering severe mental illness (Burdekin et al, 1989; Tessler & Dennis, 1989).

Increasing numbers of young women are being affected by homelessness according to The National Inquiry into Homeless Children in Australia (Burdekin et al, 1989). These young women experience every stress and adverse psychological outcome which has been documented for women, including poverty, violence, both physical and sexual exploitation and abuse, disenfranchisement, inequality and substance abuse.

The Inquiry reported that in one city (Newcastle) there was a 50% increase in juveniles appearing before the Children's Court, in the first three months of 1988. The majority of these were first offenders with no fixed address.

Accommodation options for girls and young women were more problematic than those for boys and girls, were at higher risk of exploitation and abuse. Rape, sexual violence and harassment not only occurred on the street, but also within 'refuges' when accommodation could be obtained there. Pornography, prostitution, theft and drug dealing were all resorted to as ways of obtaining money to survive. Eligibility requirements for obtaining government assistance such as possessing multiple documents proving identity, were so stringent that many destitute applicants were refused. Prostitution was often engaged in by girls in exchange for shelter, which was insecure. Sexually transmitted diseases and unwanted pregnancy were common. A study commissioned by the Inquiry (O' Connor 1988) and reported in it, notes that over half the respondents reported having first experienced homelessness while 14 years of age or younger. Physical and/or sexual abuse was commonly given as the reason for leaving home. Three-quarters of the respondents reported experiencing severe depression, just under one-third had attempted suicide and many engaged in self-harm of other kinds. Alcohol and drugs were used to dull the pain of a daily experience marked by fear, loneliness and the constant threat of violent attack. Chronic physical ill-health was also reported but cost was an insuperable barrier to seeking medical attention.

Similarly, powerlessness, high rates of stress and psychological distress and the inability to afford adequate care during illness or take preventive health care measures affects poor, single mothers. Women head one seventh of all families in the USA and one half of all families living in poverty (Carmen et al, 1981). Between 1970 and 1980 there was a 97% increase in the number of single parent households headed by women in the USA (US Department of Commerce, 1982).

There are no reliable measures of the incidence of child and youth homelessness because as the US Institute of Medicine (1988) points out, conventional methods such as the Census are based on counting people where they live and the methodological problems of counting people without a fixed address are formidable. In Australia, it is estimated that there are some 50,000 to 70,000 homeless children and young people under 18 years of age.

Multiple roles - The double shift

Since 1950 there has been a highly significant increase in the numbers of women in paid employment in Western countries. In 1950, 30% of US women were in the labour force but by 1986 this had increased to 55%. During the same period the number of married women with children under six years of age increased from 23% to 54% (US Bureau of Labour Statistics, 1988). Similar figures pertain to Australia where 50% of married women were in the workforce by 1988 and there was a 23% rise between 1981 and 1986 in the proportion of two-parent families with children under five years of age where both parents worked (Australian Bureau of Statistics, 1988). Women typically have also assumed a large burden of care for elderly parents and in-laws, which can compromise their prospects of promotion at work and lead to emotional collapse, strained personal relationships, financial hardship and poor physical health (Horowitz 1985; Brody, 1985 & Schoonover 1986).

At the same time, women as a group are concentrated in 'female' jobs and still only earn around 60% of the male wage in the USA (Carmen et al, 1981) and 65% in Australia (Probert, 1989). Hazards in traditional female employment, such as health care, clerical jobs and the textile industry may be overlooked (Lempert, 1986).

There has been no significant change in the domestic division of labour following increased workforce participation by women. Estimates of the time spent on housework and child care consistently reveal women do 90% of this unpaid work. Thus Szalai (1972) found working women averaged around three hours a day on housework, compared with the 17 minutes spent by men and about 50 minutes aday with their children compared with 12 minutes spent by men. On the other hand working fathers watched television an hour longer than their wives, slept half an hour longer (Szalai, 1972) and spent a longer time eating meals (Coverman, 1983).

Hochschild (1989) in a recent review of studies, estimated that women work an extra month of twenty-four hours days over a year. She argues there is a potent connection between lower

wages in the workforce and less leisure for women at home, with inequality outside the home operating as a lever which reinforces and recreates inequality regarding the domestic division of labour within the home.

A number of studies have been carried out which investigate the psychological impact of roles, including marital status, paid and unpaid work and child care, on the emotional well-being of women.

Marital status

There is a striking relationship between marital status and mental illness (Guttentag et al, 1972; Gove & Tudor 1973; Gove, 1979). Women's higher overall rates of mental illness in the categories studied by Gover were largely accounted for by higher rates of illness among married women. Single, divorced and widowed women were found to have rates of mental illness than men. Data analysed by Gove and Geerken (1977) revealed the best mental health was experienced by employed married men and the worst mental health by unemployed married women. The presence of children in the household generally contributed to poor mental health as found by Brown and his associates (1975, 1978, 1981, 1986).

Subsequent research has yielded contradictory results. Some researchers have argued for the mental health benefits of multiple roles, saying that paid work for women has provided them with additional sources of self-esteem, financial autonomy, increased status within the home and increased social contacts (Nathanson, 1980; Verbrugge, 1983; Kendel et al, 1985; Haavio Mannila, 1986). Others have argued that role accumulation has produced role strain, role conflict and role overload which together bring about negative health outcomes (Stellman 1977; Clearly & Mechanic, 1983; Kendel et al, 1985; Haavio-Mannila, 1986). Others have argued that role accumulation has produced role strain, role conflict and role overload which together bring about negative health outcomes (Stellman 1977; Cleary & Mechanic, 1983). Still others have stressed the need for a more sophisticated theoretical approach to the relationship between multiple roles and mental well-being. Thus Kessler & McLeod (1984) found it was not simply the number of events in women's own lives that affected them but the events in the lives of those about whom they cared. Likewise Verbrugge (1986) highlighted the importance of ascertaining how women feel about their roles; whether they have been able to choose them and organize resources to meet the demands they impose, rather than simply counting the number of burdensome events or tasks associated with a particular role. It has been found that spousal support for a woman's choices eases the stress of multiple roles (Elman & Gilbert 1984), while dissatisfaction with child care

arrangements increases it (Van Meter & Agronow, 1982).

A recent large study of over 25,000 men and women from the 1985 and 1986 British General Household Survey (Arber 1991) found family roles were important to the health status of women, confirming the finding of Hirsch & Rapkin, (1986). Previously married housewives and unemployed women were nearly twice as likely to report long standing illness compared with employed women of equivalent marital status. Arber points out that studies to date have tended to study inequalities in men's health largely in terms of their occupational role and to conceive of and analyse differences in women's health using a theoretical framework of role analysis. Thus, in an ironical parallel to the inequalities in the domestic division of labour, research has paid little attention to men's marital and parental roles and women's employment has been conceptualized as an additional role rather than a structural variable, which it is for men. Arber notes that in the Black Report (1980), four explanations for inequalities in health were provided but none considered the way in which family roles might influence health. She argues for an integration of the finding from role analysis within a structural framework so that the relative contributions of and interactions between, family roles such as marital and parental status and structural variables including occupational class, housing tenure and participation in paid employment can be clarified.

McBride (1990) also suggests the need for more careful research and more refined theoretical concepts. Notions such as social support need to be distinguished from social involvement and the particular aspects of support need to be delineated, including emotional, informational and instrumental support. Coping is another concept in need of more precise operationalization according to McBride and coping strategies must be evaluated according to their contextual appropriateness (Aldwin & Revenson 1987). Similarly, while it is well documented that depression is identified with role conflicts (McBride 1989) work is required to elucidate how role strain leads to subsequent mental disorder and what part the cognitive or attributional style of the individual may play in this (Brewin 1985 Sweeney et al, 1986: Risking et al, 1987). Care-giving obligations should be evaluated not just in terms of the number and ages of dependent children, but should also incorporate information on whether they have any health or behavioural difficulties.

Thus both Arber (1991) and McBride (1990) see the need for the development of a more thoughtful conceptualization of the problem of multiple roles and women's health.

What is needed is a move beyond the mere enumeration of events and roles to an inclusion of the subjective perceptions and understanding of the women who are directly involved with

these events and roles.

Geographical location

Research carried out in the 1970s in the USA suggested that rural women held strongly to values reflective of a traditional rural culture and characterized by conservatism, resistance to change and oriented to the family. One survey (Flora & Johnson, 1978) found more rural and urban women ageed that 'women should run the home and leave running the country to men.' A number of factors experienced more often by rural than urban women have been advanced as possible sources of greater vulnerability to stress. These include a lower level of education (Bescher - Donnelly & Smith, 1981), a lack of child care (Bigbee, 1984), geographical isolation and economic and occupational disadvantages resulting in higher levels of property and the need for public assistance (Kjervik & Martinson, 1979; Bescher-Donnelly & Smith 1981; Bigbee 1984). One study of stress among farm families (Berkowitz & Hedlund 1979) did find that farm wives identified particular stressors relating to farm life including fatigue, isolation, lack of vacations and the uncertainity of the weather. However, one later study (Hardesty, 1983) found that that main problems reported by the rural women concerned other family members and a more recent comparison of rural versus urban women in the USA (Mansfield et al, 1988) corroborated this finding and did not find that location per se was a significant discriminator of well-being as defined by life satisfaction, stress, tension, strain or exhaustion. Marital status differed between the two groups with more married and widowed women in the rural group. There were no significant differences in overall life satisfaction or stress, but the sources of each of these differed between the groups. Life satisfaction was only rated as very low for 16% of rural and 21% of urban women. For rural women, a high perceived health status, older age and being married, all predicated high life satisfaction, whereas for urban women there were no significant predictors of life satisfaction amongst those considered in the study. Stress for both groups was most oftenassociated with family and friends, which was reported by approximately half the women in both groups. The pervasiveness of stress from this source may indicate the high level of socioeconomic status, education and the number of children under 18 living at home. Interestingly, a high proportion of women in both groups reported that work never interfered with family life indicating that the increased workforce participation of rural women has not resulted in a sense of conflicting role responsibilities. Workforce participation by rural women, more than doubled in the USA between 1970 and 1980 (Bescher-Donnelly & Smith, 1981) and was linked with marked changes in rural women's traditional roles (Walters & Mckenry, 1985). The lack of role conflict and strain reported in Mansfield et al study suggests this change has been effected with little psychological cost and in this sense it is at odds with a

number of other studies which will now be considered.

5.2 The Impact of Physical and Sexual Violence

Despite the lack of inquiry concerning the presence of childhood sexual abuse in adult women with Somatization Disorder commented on by Morrison (1989), there is a growing body of literature on the short and long term effects on the mental health of women of child sexual abuse, adult sexual abuse and physical violence. However, even in 1990, some researchers felt it necessary to advise psychodynamic clinicians not to dismiss their patients' recollections of sexual abuse as 'merely oedipal wishes or fantasy' (Ogata et al, 1990).
Given the influence of Freud's view that his female patients' accounts of sexual experiences with their fathers were fantasy not reality, it is not surprising that child physical abuse was recognized before childhood sexual abuse by health professionals. Thus in 1962, Kempe and his co-workers described the 'battered child syndrome', but only in the last decade has serious attention and research been paid to sexual abuse, beginning with Finkelhor' study of 795 college students published in 1979.

Before examining the research findings on the mental health effects of childhood sexual abuse, those on physical violence will be briefly considered.

This is not to suggest that the two forms of abuse are independent of one another because as the research shows, they often occur together (Scutt, 1990).

Physical violence and the family

The family, which ideally provides the structures for nurturance, security and mental health, is often in reality 'the most frequent single locus for violence of all types including homicide' (Hilberman, 1980). And while violence outside the family is publicly condemned, violence inside the family has been and still is condoned by many as private, normal and legitimate. An Australia wide survey in 1987 found that nearly half the population knew personally, either a perpetrator or a victim of domestic violence (Office of the Status of Women, 1988). Similarly Hilberman (1980) reviewing studies carried out in the USA, reported violence occurs in at least 50% of American families. It has been estimated that up to two million American wives are battered each year (Lempert 1986). The public response to family violence is inconsistent. Both disbelief and denial that such violence occursat all (Koss 1990) and a view

accepting and condoning violent behaviour to women (Office of the status of Women, 1988) have been reported.

Violence in the family is disproportionately directed towards women and children and the assailants are typically men with whom these women have intimate relationships, rather than strangers (Hilberman 1980; Koss, 1985).

90% of physical and sexual assaults reported by psychiatric patients were committed by family members (Carmen et al, 1984).

Koss (1990) in a review of research on the mental health impact of violence notes a set of common core responses. These include a post-victimization distress response, which if not resolved, develops into longer term, chronic symptom patterns consistent with the criteria for post-traumatic stress disorder.

Further, what is interpreted by clinicians as depressed mood may in fact be long term post-traumatic responses to intimate violence. Carmen et al (1984) have argued that victimization histories in psychiatric patients tend to be ignored or misunderstood. Victims of violence are also at increased risk for repeated victimization and the likelihood of using violence against their own children (Strauss et al, 1980). However, Finkelhor (1984) has shown that while both female and male children may be violently abused, it is men who, disproportionately, go on to become abusers as adults.

Mental health effects

As pointed out in the Australian National Women's Health Policy (1989) :

'Women who suffer sexual and physical violence are at greater risk of psychological problems' (p44). Medical attention is sought in less than 50% of known cases (Walker, 1989).

Walker (1984) developed a three-phase violence cycle based on a tension reduction hypothesis. The three phases are first, a period of tension building, when the woman has some minimal control over the abusive incidents, second, a period of inevitability when the acute battering incident occurs and third, a period of loving contrition and/or no tension. Psychological responses accompanying each stage are shock and denial, terror and in response, attempts at integration and appeasement and finally depression, characterized by

withdrawn and self-accusatory behaviours (Symonds 1979). The battered woman in this situation develops learned helplessness (Seligman 1975). This concept explains the loss of the ability to predict outcomes after exposure to repeated random and variable aversive stimuli which are inescapable. Cognitive distortions including minimization, denial and dissociation and a loss of faith in their own ability to predict whether they can stop the violence are common. Victims fear confrontation and learn methods of hiding their plan to protect themselves and the abuse. They appear compliant and emotionally stable and therapists unaware of the psychological effects of family violence may terminate treatment prematurely (Walker 1989).

Sexual violence

Victims of sexual violence exhibit more psychiatric symptoms, especially depression, anxiety, somatization, obsessive compulsive disorder and paranoid ideation than non-victims (Frank et al 1979); Atkeson et al 1982; Becker et al 1984). A recent community based study found that recent rape victims were significantly more likely to meet DSM 111 criteria for current major depression and drug abuse diagnoses than for other disorders (Winfield et al 1990).

However in the remaining discussion on the effects of sexual assault and abuse the focus will be on the effects on mental health of childhood sexual abuse.

Finkelhor's (1979) study revealed that 20% of female and almost 10% of male students had been sexually abused as children.

It is known that the incidence of reported abuse cases and of rape is increasing and t hat girls are more commonly abused than boys. One estimate is that one in six women will be raped in her lifetime (Martin et al, 1983).

However, the true magnitude of the problem has still not been reliably established and numerous methodological problems exist, including variation across studies in how child sexual abuse is operationalized. This may cover acts from fondling to intercourse; single incidents or chronic abuse and include both sexual intercourse between adolescents or similar and violent attacks by adults on small children. Other difficulties include the issue of the accuracy of retrospective recall, differences in the duration which has elapsed between the age at which abuse occurred and when the study was conducted and variation in type of

sample, from self-selected clinic samples to community populations. Few studies have used standardized data collection and outcome measures or a control group or address the question of whether early sexual abuse is causally related to the outcomes measured (Browne & Finkelhor 1986; wyatt & Johnson Powell, 1988; Sheldrick ,1991).

Initial effects

Initial effects of rape and sexual abuse include fear of injury and death, anxiety, depression, anger and hostility (Herman et al, 1986; Briere & Runtz 1986; Brown & Finkelhor, 1986; Herman, 1986; Sedney & Brooks, 1984). Guilt and shame are universal responses (Lempert 1986). In the short term, one-fifth to two-fifths of abused children who are seen by clinicians show pathological disturbance (Gomes-Schwartz et al, 1990).

Long-term effects

Childhood sexual abuse is a significant predictor of long term mental health impairment. Studies of adults suggest one-fifth exhibit serious psychopathology (Sheldrick 1991). Further, despite differences in the definition of child abuse and the type of sample employed there are certain mental health outcomes which have been commonly reported in a number of studies.

Depression

The most commonly reported outcome is a dramatically increased rate for depressive and anxiety disorders. It has been found in community samples (Bagley & Ramsay 1986; Burnam et al, 1988; Mullen et al, Romans-Clarkson, Walton & Herbison, 1988) and student samples (Sedney & Brooks, 1984). The study by Mullen et al, 1988 was methodologically strong and its findings are likely to be generalizable. It was based on 2,000 randomly selected women in New Zealand and found that 20% of women who reported sexual abuse as children compared with 6.3% of the non-abused population were identified as having psychiatric disorders on the two measures of psychiatry morbidity employed in the study. Confirming the findings of other studies, 75% of the disorders were predominantly of the depressive type and the remainder were phobic and anxiety conditions.

Self-harm

Women who have experienced childhood sexual abuse are more likely to have thought about or engaged in self-destructive acts. Scratching or cutting, often to the arms and wrists is common. Other symptoms include anxiety, tension and sleeping difficulties (Sedney & Brooks 1984; Browne & Finkelhor 1986; Bagley & Ramsay 1986). In adolescence, many abused girls leave their abusive homes and become homeless, with all the consequences noted earlier.

Psychiatric diagnoses

As noted earlier, Morrison (1989) found childhood sexual abuse was significantly more common in women with somatization disorder. Briere & Runtz (1988) found an association of both somatization and dissociation with prior sexual abuse. Abuse has also been connected to hysterical seizures (La Barbera & Dozier 1980) and is frequently found in patients with borderline personality disorder (Ogata et al 1990).

Sexual adjustment and interpersonal relationships

Nearly all clinical and non-clinical studies show deleterious effects on later sexual functioning with women reporting low levels of sexual self-esteem, fear and retreat from sexual experiences and frigidity and vaginismus. There may also be a preoccupation with sexuality, increased sexual activity and masturbation (Meiselman 1978; Finkelhor 1979; Herman 1981; Browne & Finkelhor, 1986).

The fear, hostility and sense of betrayal associated with childhood sexual abuse often produces a lack of basic trust in others, compromising the possibility of women with this background being able to form close and satisfying intimate relationships. A vulnerability to victimization, prostitution and early unplanned pregnancy, a pattern seen in homeless girls, has also been reported (Fromuth 1986; Russell 1986).

Gynaecological consequences

Linking in with the findings on somatization disorder, an association between pelvic pain and

other gynaecological complaints and sexual abuse has been documented (Backman et al 1988; Harrop-Griffiths et al 1988; Draijer 1989) Harrop - Griffiths and co-workers, for example, found that 63% of women undergoing laparoscopy for chronic pelvic pain had been sexually abused as children compared with 23% of women undergoing laparoscopy for other reasons. Some women with a history of abuse have extensive histories of medical and surgical intervention. One small study of seven psychiatric patients found an average of eight operations per patients despite normal pathology findings. The women had been investigated by a variety of specialties including gynaecology, gastroenterology, rheumatology, orthopaedics and neurology suggesting that failure to deal with a history of abuse can result in numerous, costly, futile, surgical procedures (Arnold et al 1990).

Drug abuse

Finally, as Finkelhor (1984) and others have shown, high percentages of the drug abusing population have been sexually victimized as children (Brunam et al, 1988). Like all the foregoing categories, the true prevalence of this disorder amongst women who have experienced childhood sexual abuse has not yet been established. Estimates range from almost 15% of adolescents in a residential chemical dependence treatment programme (Cavaiola & Schiff 1988) to more than 70% of inpatient substance abusers studied by Rohsenow et al (1988).

Similarly, recognition and adequate treatment of the physical, psychological and emotional consequences of abuse which underlie the presenting diagnosis of drug or alcohol abuse, is unlikely to be undertaken by the staff of emergency departments or psychiatric services (Carmen et al 1984).

Chemically dependent women report affective reasons as the primary motivation for using, compared with men who report physical reasons (Cavaiola & Schiff 1988). Also women cite more family distress in childhood, over and above child abuse, including divorce, death of a family member, psychiatric illness, affective disturbance and chemical dependency. Thus substance abuse of both licit and illicit drugs may be seen as a flawed and self-destructive attempt to cope with chronic emotional distress. In adulthood, substance abuse is strongly linked to depression, anxiety, extreme low self-worth, a sense of powerlessness, the experience of traumatic flashbacks, difficulties with trust and learned helplessness, thus reiterating many of the features of other groups of women who have experienced sexual abuse in childhood (Holman & Brown 1989; Mondanaro 1989).

Adequate treatment of chemically dependent women is hampered by the stigma which attaches to substance abuse, especially alcohol, for women compared with men; poor recognition by primary care-givers that there is a problem, especially amongst middle class white women; models of treatment which have been predicated on the experience of men and are not cognizant of the issues, such as sexual abuse, which are central to substance use in women; programs which do not make provisions for children to live in with their mothers and sexual harassment by staff (Mondanaro 1989; Astbury et al, 1991; Moore & Fleming 1989).

Summary

This review has been confined to research carried out on the mental health of women in developed countries, who still live lives characterized by inequality, fear and discrimination. There is, however, no reason to believe that women in developing countries would not also experience the range of mental health outcomes which have been described, as they have even longer hours of work, both in the paid workforce and at home, are poorly paid for the work they do and are subject to physical and sexual abuse, including in some countries such as the Philipines and Thailand, forced prostitution at very early ages. Whether depression is the main adverse mental health outcome of a relatively powerless and subordinate position in society for women in developing countries, as it is for those in developed countries needs to be documented. What is clear is that there are sufficient causes in current social arrangements for depression and anxiety to be a totally understandable and realistic reaction.

6. STRESS AND WOMEN'S REPRODUCTIVE HEALTH

Stress is a frequently heard term that appears to affect many people on a regular basis, yet it is poorly understood, commonly distorted and its implications are often taken for granted. The stress construct has suffered from a lack of clear definitional criteria arising from long-standing confusion over its use as both stimulus and response. In addition, until recent years there have been few well-validated psychometric instruments to measure the subjective elements of this ubiquitous human experience.

The stress response represents the epitome of mind-body interaction, that underpins physiological and emotional arousal. Arousal, which has evolutionary value for preservation

and survival, can be both activating or inhibitory on target organs, resulting over time if unrelieved, in disease or dysfunction. A major role in the stress response is played by the individual in the ways she selectively interprets stress stimuli and their effects, and this subjective analysis serves both to initiate and maintain the stress experience. Each person is able to tolerate particular levels of stress and these highly individualistic thresholds are the product of genetic features, acquired temperament and cognitive style, and learned behaviours.

Two broad categories of stressors have been described by Everly (1989), these are : i) biogenic stressors and ii) psychosocial stressors. Biogenic stressors effect a stress response through electrical or biochemical properties that may initially bypass the higher brain centres where interpretation of events normally occurs. Some biogenic stressors, called sympathomimetics, (e.g. stimulants), activate the human stress response through direct physiological mechanisms that may override a person's interpretation of them. Psychosocial stressors, alternatively, become stressors mainly because of the individual's cognitive interpretation or meaning given to the event, the physiological arousal experience, or both. Thus, these stressors may be real or perceived events from both/either the external social environment or internal physical experience. While they cannot cause the response directly, psychosocial stressors work through the person's own cognitive appraisal mechanisms. **Clearly, the greater part of repeated stress in a person's life arises from psychosocial stressors that come to possess stress-evoking characteristics through the individual's interpretations of stimuli that are otherwise neutral** (Everly, 1989, p.7).The temporal sequences of the human stress response involves neurological, neuroendocrine and endocrine axes.

a) The neurological axis provides the most immediate response to stimuli through direct innervation of endorgans by the autonomic nervous system (ANS) via the limbic system and hypothalamus, which register emotional arousal and cognitive interpretations of the arousal experience. The parasympathetic and sympathetic branches inhibit or activate endorgans and though the effects can occur simultaneously and immediately, these responses are not sustainable over time without some additional impetus.

b) The neuroendocrine axis is responsible for the active coping response system termed the "fight/flight" response by Cannon (1929). Activation of this pathway from the amygdalar complex, via the hypothalamus, to the adrenal medulla causes output of the catecholamines, norepinephrine and epinephrine, which activate the sympathetic ner vous system. Three different patterns of catecholamine output have been identified in relationto qualitatively different attentional states.

These are : i) the defence or "flight" pattern, characterized by high levels of epinephrine ii) the immobile or "freeze" pattern, accompanied by high levels of norepinephrine; and iii) the vigilance or "fight" pattern that is reflected in high levels of testosterone. Activation of the sympathetic adrenal medullary system appears to occur following a 20-30 second delay phase but it produces a tenfold increase in the duration of effects

c) The endocrine axis is responsible for chronic, prolonged somatic responses to psy chological and psychosocial stimuli. This final path way, the hypothalamic-pituitary-adrenal-cortical system, which requires maximal stimulation, functions via activation of four hormonal axes:

   i) the adrenocortex, releases glucocorticoids and mineralocorticoids with a minor release of norepinephrine and epinephrine. This profile characterizes the so-called "passive copingsystem", related to subjectivefeelings of help lessness, hopeless ness, loss of control and depressed immune response;

   ii) the somatotropin axis, that mobilizes the output of mineralocorticoids (aldosterone, deoxycorticosteroids);

   iii) the thyroid axis which alters the rate and quality of general metabolism; and

   iv) the posterior pituitary axis, which is responsible for release of luteinising hormone (LH), vasopressin, prolactin, testosterone and oxytocin.

The role of the individual's cognitive processes in the stress response has been the subject of considerable debate regarding whether cognition occurs primarily or secondarily in person-environment transactions (Lazarus, 1984; Zajonc, 1984). Several leading research-ers (Ellis, 1962; Lacey, 1967; Lazarus, 1974; Schwartz, 1979) give support to the cognitive system as one of the key factors in stresstransactions and as a necessary precondition for emotional experience (Arnold, 1970; Beck, 9176; Ellis, 1962; Lazarus, 1980). Individual differences also function to determine the quality of cognitive interpretations and inferences that are made about perceived and real demands. Some people appraise many events as challenges to be mastered. It appears the qualitative differences of the individual's cognitive determination mediate the hormonal patterns of response. Frankenhaeuser (1980) has identified three patterns of hormonal reponses linked to cognitive states:

   i) activation of the sympathetic adrenal medullary axis when demands are inter-

preted as challenges ("effort without distress");

i) activation of the hypothalamic-pituitary-adrenal-cortical axis when demands are interpreted as overwhelming and defeating ("distress without effort"); and

iii) activation of both the sympathetic adrenal medullary and hypothalamic-pituitary-adrenal-cortical systems when demands are interpreted as threatening ("effort with distress").

6.1 Stress and Gender

The stress response is a complex process for both men and women but some differences between the sexes have been identified. Most notably, the physiological response to stress by women is qualitatively different along the adrenal-medullary pathway. When experiencing mental stress tasks, Collins (1985) reported that women respond with lower levels of epinephrine than do men. However, the subjective reports of women's perceptions of stress arousal tend to be greater in terms of emotional discomfort and lack of confidence than the actual levels of circulating epinephrine would suggest. This finding could indicate that women respond with greater emotional arousal to smaller amounts of hormonal activation than med do, or that they have a lower tolerance threshold for experience of physical arousal.

Women's sex-role orientation has been linked to differential psychophysical outcomes in measures of sympathetic adrenal medullary hormones (Collins, 1985). It was found (Collins, 1985) that women engineering students with demonstrated 'masculine' interests and capabilities, excreted higher levels of epinephrine during stress tasks than did women scoring highly on more traditional 'feminine' characteristics. Similarly, several earlier reports on menstrual cycle dysfunctions reported that feminine sex-role acceptance was negatively related to menstrual acceptance and satisfaction (eg. Berry & McGuire, 1972; May, 1976; Schneider & Schneider-Duker, 1974; Gough, 1975). Other researchers (Spencer-Gardner et al, 1983) reported no differences in sex-role identity between women with or without menstrual cycle problems. In a review of the relationship of sex-role identity and adjustmentin women, Thomas and Resnikoff (1984) showed that a feminine role identity was not especially related to psychological distress. The more important factor was 'instrumentality', i.e. in women, Thomas and Resnikoff (1984) showed that a feminine role identity was not especially related to psychological distress. The more important factor was 'instrumentality', i.e. the perceived freedom to be active and instrumentally effective in directing one's life. Individuals

with optimal emotional health were those with a combination of androgynous (A) scores combined with either masculine (AM) or feminine (AF) characteristics. The androgynous feminine (AF) women emerged as the most emotionally stable, even more than women who scored high on either M or F characteristics.

Although there is some support for differences between individuals in catecholamine release to stressors, there also appears to be intra-individual constancy in the amount of secretion and the time taken to return to resting levels after a stress experience has passed. Indicators of appropriate or inappropriate hormonal response to stress has been referred to as the 'economy-inefficiency' dichotomy by Frankenhaeuser (1975). The 'economic' adjuster appears to respond to stres experiences with a rapid output of epinephrine, they score low on measures of neuroticism and high on tests of performance. Post-stress, these individuals show rapid return in hormone profile to pre-stress levels. Conversely, the 'inefficient' adjuster demonstrates a slow rise in catecholamine output to stress experiences and levels remain higher for longer, resulting in an overuse of unrequired physiological resources that is indicative of poorer psychophysical adjustment. Thus, while some evidence indicates that sympathetic adrenal medullary responses to acute stress may be gender-specific, indicated by evidence of greater 'economy' in physiological response by women (Frankenhaeuser, 1978; Collins, 1985), alternatively women more than men simultaneously show greater psychological costs in terms of profound negative emotions and a lowered sense of success and self-satisfaction. In a general consideration of health-related behaviors, more women than men readily seek professional help and disclose concerns (Everly, 1989). This is frequently regarded as an indicator that women suffer higher 1989. This is frequently regarded as an indicator that women suffer higher morbidity in acute conditions and nonfatal chronic conditions though lower mortality rates at all ages (Verbrugge, 1985) An alternative hypothesis refers to the fact that women bear the burdens of a greater diversity of roles and responsibilities for others than do men, so the potential for stress-related incidents and burnout is greater (Newman, 1989). A third view is that women are protected from serious life-threatening ill health during their reproductive years due to a biological protective factorafforded by high levels of overian steroids, particularly oestrogens. The lower incidence of vascular and hypertensive diseases in women is related to the facilitative oestrogenic effects on lipid control. During the reproductive years, women also appear to have higher levels of high-density lipoproteins (HDLs) that aid in removal of cholesterol from the bloodstream and limit the development of atherosclerotic lesions. However, as more women desire and are encouraged to compete with men in occupational terms and in self-dependency, this picture may alter over the coming years. The question whether gender differences in health are biological, psychological, environmentally determined or the result

of multiple mixings of these factors is not able to be answered at the present time.

6.2 Stress and Women's Health

In traditional thinking and writings, the mind-body separation persists through theories of aetiology for health disorders that are proposed as either biological or psychosocial. This approach is outdated and Weiner (1977) proposes that serious efforts should be made, by researchers and clinicians alike, to consider an integrated perspective of contributing factors to the instigation and maintenance of any problem in health or well-being. Regarding psychobiological factors in bodily disorders, the view of Weiner (1977) is to be commended, that sick people exist, rather than diseases as particular entities. It should be recognized that preexixting factors within and around the individual from biological, psychological and social sources all prevail to influence any condition affecting health.

A Stress Model of women's health takes into account individual differences in symptom experience, symptom tolerance and reporting behaviours as stable characteristics of people. These psychological antecedents interact with factors from the social milieu, with co-existing physiological predispositions and response styles. This multifactorial framework can be understood within the rubric of Bandura's (1977) triadic reciprocality system.

A modified triadic reciprocal model is proposed that acknowledges the flow of forces as interrelational and multidirectional between the women's psychological characteristics, her internal physiological makeup and the conditions of her social environment. The emphasis is on dynamic, ever-changing relationships with events that have stressful potential.

6.3 Reproductive Functioning

For many years, the human menstrual cycle has been shown to be stress-sensitive (Dalton, 1960; Reichlin et al, 1979; Awaritefe et al, 1980; Woods 1985) in relation to excessive self-imposed or external demands; conflicting roles; failed aspirations; threat-laden social demands; perceived low self-efficacy; and laboratory-based experimental stressors. The hypothesized role of stress appears to alter the regular physiological features of the menstrual cycle, and to result in the subjective experience of symptoms.

The sympathetic adrenal medullary and hypothalamic-pituitary-adrenal cortical systems are

exquisitely sensitive and responsive to a wide range of psychosocial stimuli that involve novelty, change, threat, challenge or conflict (Mason, 1975; Lazarus, 1966). Any subjective state of under-stimulation, stimulation, or over-stimulation is characterized by particular profiles of hormone and neuroendocrine production that correspond directly with subjective reports of intensity of arousal, discomfort or unpleasantness (Mason, 1975); Frankenhaeuser, 1975; 1980).

In normal women distinct menstrual cycle phase effects in catecholamine production to experimental stressors have been shown to occur, with the highest values occurring in the luteal phase, together with the usual pattern of high levels of oestrogen and progesterone (Collins, et al, 1985). As reported above, the lower levels of catecholamine output produced by women in response to a variety of naturalistic stressors, and the greater intensity of negative feelings about the stressful experience (Frankenhaeuser et al, 1978), indicate that the psychoendocrine stress response in women, differs not only between the sexes, but also is influenced by the synergistic effects of ovarian hormones across the phases of the menstrual cycle. Further, the gender-specific qualitative differences in the hormonal profile of the stress response is illustrative of individual response specificity, reflecting both personal control factors and sex-role orientation (Collins & Frankenhaeuser, 1978; Collins, 1985).

When considering social factors in stress experiences, a great deal of attention has been given in earlier years to the effects of major life events on physical and emotional health (e.g. Dohrenwend & Dohnrenwend, 1974). Later writers (e.g. Billings & Moos, 1982) have regarded the causal direction of this relationship as uncertain. Recently, researchers have acknowledged the enduring effects of *daily roles* as more salient in producing adverse effects on health and well-being. The underlying life events (e.g. unemployement, divorce, financial hardship, bereavement) though of powerful impact, are events of low frequency that allow ample time and opportunity for recovery once the stress of the event recedes as the problem resolves. Conversely, the stress occasioned by life's daily roles, termed 'daily hassles' (Lazarus & Cohen, 1977) is ubiquitous, arising from those minute but multiple, frustrating demands and challenges that impinge most frequently on the individual. This means that psychological and somatic responses are constantly triggered which, over time, if ineffectually managed, can result in reduced well-being and disordered health. Thus, Pearlin (1983) calls for consideration of role strains as potentially powerful antecedents in the stress experience. Role strains refer to the difficulties, conflicts, threats and challenges that people experience in their chosen social roles that impinge on the four main role arenas of parenting, marriage, economy and occupation. Six types of role strain have been identified (Pearlin,

1983, p.8). These are : a) problems in the nature of tasks required to be performed; b) problems with having too tittle (under-extension) or too much (over-extension) to undertake; c) involvement in too many simultaneous tasks (over-load); d) feeling trapped in an undesirable or unsatisfactory role (role captivity); e) role gains (e.g. marriage or parenting) or role losses(e.g. divorce, redundancy); and f) role restructuring (e.g. adult children becoming independent). Over the lifespan, the critical element that determines the individual's success in managing the various gains, losses or restructuring of roles is the amount of personal readjustment required of the person at the psychological level as each change appears. When demands outstrip the woman's psychological abilities for adaptation then strain is experienced. Adverse psychological factors that work against successful adjustment are anxiety-proneness, perfectionistic attitudes, inflexibility or dogmatism, negative self-concept, low self-esteem, and low confidence in one's ability to be effective (self-efficacy). Each one of these factors can seriously disadvantage the process and progress of adjustment to social strains (Bandura & Admas, 1977, Petrie & Rotherham, 1982; Hewitt & Dyck, 1986). Adjustment refers to coping strategies that facilities the management of emotional arousal, physiological sensations of activation, and behaviours. Thus, the view of Lazarus and colleagues (1980) that ill-health develops from failures to cope effectively with changing demands can be readily assimilated. From the previous section, it is clear thattransactional effects from the individual's personal abilities and social conditions play important parts in influencing emotional and physical health outcomes. This perspective of continuing transactions between the individual, her social world and internal physical systems is further illustrated below through examination of two problems of women's health - premenstrual syndrome and postpartum depression.

6.4 A Psychobiosocial Stress Model and Premenstrual Syndrome (PMS)

Premenstrual Syndrome has been generally thought to be due to subtle defects in luteal phase hormones in terms of oestrogen-progesterone imbalance (Backstrom et al, 1983; Dennerstein et al 1984). Luteal phase hormonal defects are hypothesized to produce recognizable symptom clusters of negative moods, information-processing deficits, uncontrolled behaviours, physical discomforts and negative self-concept, that appear in the ten days prior to menstruation and disappear by the end of the menses (Dalton, 1977). Recent studies (Backstrom et al, 1985; Rubinow et al, 1988), however, have failed to find any exact hormonal defect to account for this common but perlexing syndrome.

The role of stress in PMS has usually been considered from a common sense perspective

of outcome of the syndrome. Rarely has stress as antecedent been seriously considered or investigated. A study from the University of Melbourne (Morse et al, 1988) found the two main differentiating features between a group of treatment-seeking women and community volunteers were reports of subjective stress and depression in the follicular (day 6-8) phase as well as during the premenstrual phase (day 25-27 of an adjusted cycle). This finding suggests that PMS suffers are stressed, depressed women, throughout the cycle, so that a singularly clear hormonal hypothesis of causation is unlikely to stand alone without consideration of contributors from psychosocial sources of strain. Recently, Rabin and colleagues (1990) reported significant differences between sufferers and controls only in transient nocturnal Adreno Cortico Troptic Hormone levels. The authors proposed that the transience of the hormonal stress response could explain why i) the gross features of the menstrual cycle appear to continue undisturbed in PMS sufferers (e.g. ovulatory cycles; regular menstruation) and ii) that the servo-mechanisms of the neuroendocrine pathway are resilient in preventing the development of aberrations to appear as grossly disordered menstrual cycles.

The psychological profiles of PMS sufferers are very well documented in many studies and the typical findings include high neuroticism, introversion, high trait anxiety and anger, marked cognitive failures, low self-esteem and ineffective coping skills (Rees, 1952; Coppen & Kessel, 1963; May, 1976; Spencer-Gardner et al, 1983, Morse et al, 1988).

As indicated above, according to Frankenhaeuser and her colleagues (1975; 1978; 1980), women generally respond to experimental and natural stressors with a moderate activation of catecholamines, but with a pronounced subjective experience of intense negative feelings that is arguably out of proportion to the level of hormonal activation. So in PMS sufferers, who characteristically are intrinsically high anxious women, it is to be expected that subjective reports of distress would be considerably greater in intensity compared to actual levels in hormonal profiles. This proposition seems to be the case as reported by Rabin and colleagues (1990) and as found in a current study in our centre (Morse et al, in preparation).

It should be borne in mind that most of the reported symptom clusters in PMS can be identified as psychological in nature and further, that treatment-seekers commonly report "Failure to Cope" during their premenstrual phases. This self-determined evaluation clearly reflects the women's own perceptions of inadequate personal control over environmental conditions. Cortisol excretion is of interest in several psychopathological states and can mainly be considered as an indicator of anxiety and felt-distress (Fredrikson, 1989). Fluctuations occur in cortisol excretion levels depending on the individual's subjective sense of competent control or self-efficacy (Bandura et al, 1985). Some studies have reported increased cortisol

levels in situations of low control (Miyabo et al, 1979; Arnetz et al, 1987); while other studies (e.g. Frankenhaeuser, 1978) have reported alteration of cortisol output during conditions of self-paced reaction tasks. Thus, the interaction of anxiety, perceived control and cortical excretion could be of immense importance of anxiety, perceived control and cortisol excretion could be of immense importance in understanding the psychophysical pathways that contribute to the experience through the applications of stress management training to increase self-effcacy or coping, together with the concurrent measure of cortisol and catecholamines. It could be that control gained with effort and learning may be significantly related to altered patterns (i.e. 'normalized' levels) of neuroendocrine changes in PMS sufferers as other studies have shown (e.g. Bohlin et al, 1986; Bandura et al, 1985). This hypothesis awaits further evaluation.

6.5 Psychosocial Stress Model in Postpartum Depression (PPD)

A common medical view is that the postpartum phase is the time of greatest risk for a serious depression in women (Brandon, 1982; Dennerstein et al, 1989). Postnatal negative moods and depression in new mothers have been documented for centuries, but in some reports many of the mood problems resolved within a short span of time, while others reported (e.g. Uddenberg and Engelsson, 1978) enduring mood problems which resulted in personal, parenting and marital distress that can have long-term effects over years (Tonge, 1986; Uddenberg & Engelsson, 1978).

Several hormonal hypothesis have been proposed to account for the onset of postnatal depression. The ovarian hormone sensitivity hypothesis (Dalton 1971) proposes that certain women respond with considerable negative feelings to the profound reductions in physiological levels of oestrogen and/or progesterone in the postpartum phase after the unusually high levels maintained during pregnancy. This proposal has some intuitive appeal based on the evidence that women tend to report greater psychological mood experiences to stress inductions that occasion only moderate elevations of hormonal response. More importantly, this view of hormonal 'sensitivity' refers, in fact, to sensitivity to changes in hormone equilibrium and suggest that certain women adapt to physiological shifts with greater difficult than others do. This hypothesis has also been proposed to explain premenstrual negative moods in PMS sufferers as due to poor adaptation to oestrogen and/or progesterone withdrawl prior to menses (Dalton, 1964; 1977). In addition, some studies have reported that significant proportions of women experience both PMS and PPD (e.g. Gard et al, 1986; Dennerstein et al, 1988), while other studies (Harris, 1980; Stein, 1980) have shown no

relationships between either menstrual cycle problems (dysmenorrhoea, PMS) or gynecological disorders (infertility, dysfunctional bleeding, spontaneous abortion). High levels of prolactin occurring postpartum through breast-feeding practices have been implicated in the onset of depression in predisposed women. Alder and Cox (1983) reported a twofold incidence of depression in women providing total unsupplemented lactation compared with mothers providing only partial breast feeding. Overall, none of the various hormonal hypotheses has been unequivocally supported in well designed prospective studies to account for the onset and maintenance of depression in new mothers. In addition, the onset of depression can occur at any point of time removed from parturition, yet the temporal relationship is presented as the explanatory feature to provide both a label and a theory of aetiology.

A challenging view of Oakley (1980) is that PPD is a 'pseudo-scientific tag' for maternal discontent that arises in response to the collected strains impinging on the new mother. The sources of stress that strain her include economic, marital, social and predominantly physical changes and psychological demands of her new role, either for first-time mothering or for subsequent deliveries (Elliot et al, 1988). These five categories of stress that affect the newly delivered woman are listed in Table 1.

The two major categories of physical change and psychological stress provide numerous instances where demands can outstrip the woman's capabilities to successfully manage her new state as a mother. Over time, it is likely her responses become increasingly frantic and simultaneously less effective in outcome so that her confidence in both knowing how to respond and being able to do so, becomes seriously damaged. Initially, efforts may be made to cope often by foregoing opportunities for her own rest or food intake. These desperate attempts are both triggered and maintained by feelings of anxiety, guilt and not uncommonly, hostility. When questioned, mothers admit, shamefacedly, to feelings of hostility towards the tiny demanding creature who recognizes no limits; or towards the partner who seems incapable, unwilling, or both, to assist her adequately; and towards herself for being so incompetent and ineffectual. This state of affairs leads to a downward spiral into increasing helplessness and the hopelessness characteristic of profound depression.

Several researchers have reported that PPD sufferers report being either unprepared for the demands that parenthood imposes or they have held unrealistic expectations of parenting (Moss et al, 1983). Thus, either or both parents may be seriously surprised or discomforted that their prenatal lifestyle has to be considerably altered to accommodate its new member. Or, that many parenting tasks are unpredictabe and are unable to be reliably planned for

ahead of time. In an English study Elliott (1985), found that mothers were disappointed and critical of much of the antenatal education offered in classes about the postnatal experiences to be expected. Often, most preparatory education for childbirth focuses on the pregnancy and delivery, with very little information imparted about the immediate and later postnatal stages. Lack of knowledge and preparedness then renders prospective parents at risk for becoming overwhelmed and defeated.

The Depression-Prone Woman-Psychological Vulnerability Hypothesis

How well a woman adapts to the physical, emotional and life changes engendered by conception, pregnancy and delivery depends on several factors. These include childhood family experiences; the quality of family relationships; previous mood disturbances in relation to menstrual cycle phases and use of hormonal agents; the quality of her relationship to the baby's father; current personal relationships and quality of social support networks.

In the voluminous literature on depression, a depression-prone core in the personality has been referred to by many writers (see Coyne, 1985, for review). While some have disputed a particular personality profile as indicative of vulnerability, women who have difficulties in adapting to change and demands are more likely to experience high anxiety (Beck & Emery, 1987). Anxiety-proneness triggers and maintains feelings of threat and being overwhelmed in myriad circumstances. These emotional experiences underpin ineffective coping behaviours, leading ultimately to depression. The central element, which may arise through genetic, constitutional or socialisation factors, appears to become activated by real or perceived losses or threats that trigger depressogenic thinking about events and experiences. This readiness to interpret life events as threatening demands is frequently aggravated or supported by mixed messages of support or approval, or even rejection, from significant others in their lives. In Coyne's (1985) view, depression results from responses to serious disruptions of the social environment in which support, comfort and validation of one's value and worth is usually obtained. In addition, Billings and Moos (1985) have linked depression to the failure of intra-individual qualities of personal control, hardiness, coping skills, and resistance that normally maintain satisfactory interpersonal relationships. In their view, depression reflects poor relations and marital dissatisfactions that antedate the depression experience. These social strains produce maximal impact in those least able to negotiate more satisfying experiences. Thus, the depression-prone person tends to exhibit demands for control and perfection prior to making decisions; they expect more of their relationships

than is possible, or justified, or appropriate; and they are rigid and inflexible in problem-solving and decision-making (Beck, et al, 1979).

The parturient woman who experiences a serious non-psychotic depression may be identified prospectively by a conglomeration of factors. These include: a history of childhood depression; depressed feelings during pregnancy; obstetrical risks at delivery; adverse psychological factors that influence competence, coping and adjustment; low satisfaction with parental and marital relationships; poor quality of social supports; and limited knowledge and preparation for the practical demands of child care (O'Hara et al, 1984). Jansen and colleagues (1991, in preparation) have carried out a long term follow-up of a group of mothers three years after a bout of postpartum depression. A significant finding was that the depression scores on the Beck Depression Inventory at the three year evaluation were predicted by the depression score obtained at 28 weeks gestation during the pregnancy. This indicates that certain women may be regarded as psychologically vulnerable (Cohen, 1979) by virtue of their personal processing style and/or social strains that may co-exist.

These identified features provide a considerable challenge to the helping professions to develop both curative and preventive strategies to protect those women most at risk. A preliminary pilot program was developed for this purpose at the University of Melbourne (Morse, 1990) that would benefit from formal evaluation and refinement. this remains an empirical issue for future research.

Summary

Considerable research has revealed that women experience and respond to stress in distinctive ways compared to men. Women's stress response process is both qualitatively and quantitatively different in terms of hormonal profiles, activation of the sympathetic adrenal medullary and hypothalamic-pituitary-adrenal-cortical response pathways, and in emotional quality. Their typical stress response is also attenuated by the phases of the menstrual cycle related to the synergistic effects of the ovarian steroids. In addition, the nature of women's lives and realities renders them at risk for stress-related effects more often than men. Only perhaps do single fathers with dependent children approach the sheer level of multiple responsibilities that the majority of women carry. It is clear that those who are particular personal difficulties succumb at some point or another. The task of society is clear, that of affording the maximal protection, help and support to those women who, for one or another reason, have been disadvantaged biologically, psychological or socially in their pursuit of health and well-being.

7. MENTAL HEALTH ISSUES FOR WOMEN

In a recent editorial in the British Journal of Psychiatry, Pilowsky et al (1991) commented that although women are the major mental health consumers, their special needs have yet to be understood and accounted for in service planning. Service development may be understood from the life cycle perspective (Subotsky, 1991). In childhood specialized services may need to be developed for girls to deal with the problem of child sexual abuse. Despite the frequency of child sexual abuse and the preponderance of girls to boys so affected, UK figures from annual reports show that local child psychiatry services see more boys than girls (2:1). The major reasons for the gender difference are evidently to do with troublesomeness rather than other criteria for disturbance or distress. There are two major types of serious problems where young women present more often than young men - eating disorders and self-harm or para-suicide. Sexual abuse may be an important predisposing factor in both conditions. Methods of intervention need continual development. Psychological problems during adulthood may be associated with menstruation, such as premenstrual tension, fertility control and infertility. women's experiences of difficulties in their sexual relationships range from communication problems to servere physical and sexual abuse, which increase their vulnerability to psychiatric disorder (Mullen et al 1988).

Single and repeated pregnancy losses through termination, miscarriage or stillbirth may have effects on a woman's emotional adjustment over many years. Support groups and practice policies are needed to ensure women are dealt with sensitively and appropriate counselling is available. Special services are needed for psychiatric disorders associated with the postpartum and women's experience of psychological distress as mothers, especially of young or handicapped cycle of family stress. Other special areas include those of meno-pause and mid-life symptoms and the effects of surgery on female organs (hysterectomy and mastectomy). Sexual harassment and sexual assault are a general risk in institutions caring for vulnerable patients. Alzheimer's disease affects women disproportionally as sufferers, because of their greater life expectancy, and also as carers. Emotional disturbance is common amongst the careers of the elderly mental infirm (Gilleard et al, 1984) but there is some evidence that community provision can help to relieve the distress (Gilhooly, 1984).

7.1 Fertility

A cultural perspective on the interaction between fertility, mortality and mental health was provided by LeVine (1991). LeVine describes how the demographic transition by which birth

and death rates decline towards the low levels currently found in Europe and North America and East Asia, is associated with an increase in the labour intensity of infant care. Mothers in post-transitional societies, with low rates of fertility and child mortality respond to the care of infants in a labour intensive way, responding to their infants with speech in a manner that demands their full attention when the baby is awake. Mothers in agrarian populations postpone verbal communications to a later stage of the child's life, while following a cultural model of protective infant care that involves constant holding, comforting and physical contact but permits the mother to divide her attention between infant care and other tasks such as cultivation and food processing. Maternal school attendance seems to be the primarydeterminant of labour-intensive infant care not only across different populations but also within populations undergoing transition. Labour intensive infant care operates, through the behavioural development of the child to facilitate the decline in mortality and fertility. Verbal exchange fosters verbal interaction in the post-infancy period so that the child will demand attention to his needs in sickness and health and is less likely to be neglected. This is consistent with reports that is after the first year of life that the relationship of mother's school attendance to mortality is most robust. This also fosters the development of a preschool child who is active, demanding and requires increased maternal attention leading mothers to favour reduction in fertility and the acceptance of contraception. Such labour intensive childhoods lead to expectations from children for continued support and attention. This may create new vulnerabilities as well as strengths in the psychosocial development of children. Blake (1989) has demonstrated that the number of siblings with whom one is raised is inversely related to school performance in the USA. Children whose early experience has generated such expectations for continued interaction and support may be vulnerable to discontinuities occasioned by separation, death, mood disorder, parental neglect or abuse.

Reproductive health care has an important role to play in increasing the choices women have in planning their lives and in the control over their health and bodies (Amaro 1988). In order to serve each population adequately, providers must become more aware of the beliefs, expectations and problems experienced in order to design services which respond to their needs. Amaro (1988) highlights how previous investigators have studies Mexican-American women's reproductive behaviour distally, relying on fertility rates and epidemiological data. This approach does not provide and understanding of how Mexican-American women experience interactions with the health care delivery system, with their partners and with social institutions, like religion. The need for a proximal approach is indicated to provide information on how Mexican-American women make contraceptive decisions, how they carry them out, what roles their sexual partners play in the decisions and what problems women encounter.

7.2 Motherhood and Mental Health

Pregnancy involves a critical role transition. For most women, it is a stressor leading to resolution and growth. Maladaption will lead to personal distress and threaten the integration of the family unit. Lewis and Cooper (1988) found that there was a greater impact of the transition to parenthood on women than on men and there were some cases of extreme stress.

Motherhood represents a major change in the life cycle, a biological psychological, social and cultural event. While community expectations are for "blissful motherhood", there is growing evidence that many women suffer considerable psychological distress in the 12 months after childbirth. Epidemiological studies have found this to be the time of greatest risk for psychiatric illness in a woman's life (Brandon, 1982). Some workers report a five to sevenfold increase in psychological disorder (mainly depressive reactions) postpartum (Pitt, 1968).

The relative risk for a woman to be admitted to a psychiatric hospital with a psychotic illness in the first month after childbirth is about 22 times greater than in any of the 24 months preceding delivery; such an admission is 35 times more likely after the first baby (Kendell et al, 1987). The increased incidence combined with the short delay between childbirth and onset of the illness, and the early symptoms of perplexity and confusion suggestive of an organic distrubance, add weight to the primary aetiology being in the physiological domain with psychological and social factors of secondary importance. Hemphill (1952) studied rates of admission to mental hospital for puerperal illness from 1938 to 1948 and found no difference in rates in the war years, despite the presence of many severe social circumstances then. The main and consistent associations with postpartum psychotic breakdown were primiparity (2/3 of all cases), past history of bipolar illness or of postpartum psychosis, a family history of bipolar illness, Cesarean-section, prolonged and difficult labour, stillbirth and being a single mother. The increased risk of puerperal admission associated with stillbirth or neonatal death appears to be limited to non-psychotic illness (i.e., linked to depression).

Psychological disorders postpartum may be classified as follows : postpartum blues, postpartum psychoses, postpartum depression, and disorders of the mother-infant interaction.

Postpartum Blues

This disorder is variously known as maternity or postpartum blues. In the community this is known as 'baby blues' and the 'weepies'. The symptoms of postpartum blues occur in the first ten postpartum days with a peak onset around days 3 to 5 (Pitt, 1973). The symptoms can last for several hours or be present for several days but they decrease quickly and disappear before day 10 (Pitt, 1973). The features of the blues have beenreported to include: weeping, depressed mood, lability of mood, sleep disturbance, anxiety and irritability, confusion and cognitive impairment. The incidence of this disorder (depending on the criteria) has ranged from 15% up to 84% (Oakley & Chamberlain, 1981). Most authors have concluded that the postpartum blues is a benign and transient disturbance, requiring recognition, explanation, empathy and support.reported to include: weeping, depressed mood, lability of mood, sleep disturbance, anxiety and irritability, confusion and cognitive impairment. The incidence of this disorder (depending on the criteria) has ranged from 15% up to 84% (Oakley & Chamberlain, 1981). Most authors have concluded that the postpartum blues is a benign and transient disturbance, requiring recognition, explanation, empathy and support.

Postpartum Psychosis

Postpartum psychosis is the most severe disturbance which may be experienced in the puerperium and occurs with a frequency of 1 to 2/1000 births. The onset of this disorder occurs in close association to childbirth, usually within the first 1 to 4 weeks after birth (Kendell et al, 1976, 1987). Kendell et al (1987) reported the highest rate of admission within 30 days postpartum, occurred 1 to 7 days after birth. The incidence was still higher than that of prepregnancy at 21 months pospartum. There is a great deal of controversy about whether postpartum psychoses should be considered as separate entities, differing from other psychoses should be considered as separate entities, differing from other psychoses. Several studies reveal that more women tend to experience affective illness, depression and mania, than schizophrenia during the puerperium (Brockington et al, 1981; Kendell et al, 1987). Studies comparing the phenomenology of psychoses occurring after delivery have reported some differences from nonpuerperal psychoses (Dean & Kendell, 1981; Hayes & Douglass, 1984). For example, Brockington et al (1982) comparing 58 episodes of psychotic episodes found an excess of manic symptoms in the puerperal group. Hayes & Douglass (1984) compared a group of nonpuerperal patients with a group of puerperal psychotic patients. They reported that the puerperal group experienced significantly more "gross

thought disorder, misperception (particularly visual stimuli), insomnia, an anxious and hectically variable mood and auditory hallucinations". Catatonic symptoms were also present but to a lesser degree than those in the manic depressive group. Following the acute phase the puerperal group was found to be significantly characterized by the syndrome of unipolar depression. Brockington and Cox-Roper (1988) propose a single category for all acute nondepressive psychoses which begin within 2 weeks of delivery. This would include those patients who meet RDC for mania, schizoaffective mania, schizophrena or undiagnosed functional psychosis begin within 2 weeks of childbirth, irrespective of social circumstances. These authors cite evidence in favour of such disorders being considered as biopolar illnesses. They also favour diagnosis of a specific puerperal depressive psychosis which begins in the first 2 weeks after childbirth, meets RDC criteria for major depression with the presence of delusions. hallucinations or confusion.

Shoeb and Hassan (1990) estimated an incidence of postpartum psychosis of 3 per 1000 births in the Assir region of Saudi Arabia. 66% of the psychoses were affective in nature.Swift (1972) reported 42 Tanzanian women admitted in Dar es Salaam with puerperal psychoses. A quarter of the women had a previous history of a febrile illness and Swift emphasized the need to exclude a physical cause for a psychosis such as infection, malnutrition or anaemia (Swift, 1972). In a study of Nigerian women with puerperal psychoses, Ebie (1972) also found a high incidence of schizophrenia or organic psychosis.

In a later Nigerian study, 12% had an organic psychosis, 20% had schizophrenia, 28% had worries and 34% had depression. These findings again emphasize the importance of physical complications in the puerperium -2 mothers with organic psychosis died (Ifabumuyi & Akindele, 1985).

In Senegal, Colomb et al (1972) reported that a third of women admitted to the mental hospital between 1965 and 1969 had a puerperal psychosis. The high incidence was attributed to a high fertility rate and the prevalence of disabling fears or anxieties among pregnant women.

Postpartum Depression

There is growing concern amongst health care workers about the much larger number of women who suffer from postpartum depression. The nature of the condition is often not diagnosed, despite evident distress and difficulties in coping with the child. Recent prospective research has drawn attention to the pervasive and widespread effects of this disorder.

Postpartum depression causes considerable distress to the new mother, interferes with her attachment to her baby and the baby's development, and with marital, family and social relationships (Tonge, 1984). Recognition, early treatment and if possible, prevention, may thus help in promoting the mental health of the woman and her family. Postpartum depression has been variously termed puerperal depression, postpartum depression, neurotic depressive reaction, neurotic disorder, atypical depression and maternal depression. Several studies providing data on the duration of this disorder have reported a range of one week (O'Hara et al, 1984) to 4 years (Uddenberg & Engelsson, 1978). Watson et al (1984) reported that 25% of their depressed women had episodes lasting 3 months and a further 25% of their depressed women had episodes lasting 6 months or more.

The period of onset for depression which has been regarded as puerperal has varied from one week to one year postpartum. Tonge (1984) in an Australian study reported that women were six times more likely to become depressed within the first 4 weeks and all of the women who were depressed became so within the first six months.

Postpartum depression refers to a common and serious disorder in which there is a persistent lowering of mood. Features of this disorder summarized by Oppenheim (1983) and Cox (1983) include feelings of inadequacy, difficulty in establishing a new routine, inability to cope, social withdrawal and despondency, guilt over not loving or caring enough for the infant, mood lability and depression, often in conjunction with anxiety over the baby. This anxiety can often manifest itself in somatic concerns, anorexia or weight gain. Other symptoms include loss of sexual interest, undue fatigue and exhaustion, sleep disturbance including difficulty getting off to sleep and early morning awakening, obsessional thinking and fear of harming the infant. Depression might not necessarily be the leading symptom. Symptoms can vary in intensity from day to day and are reactive to circumstances, often with a tendency to worsen as the day progresses. Prospective studies using standarized diagnostic criteria have reported an incidence of depression of 12-14% at 3 months after birth with a period prevalence of 22-24% for all episodes in the first postnatal year (Kumar & Robson, 1980; Watson et al, 1984).

The aetiology of postpartum depression is unlikely to be attributed to a single cause. It would seem appropriate to view depression after birth within a multidimensional model. Biological, psychological and social factors are likely to be interrelated in several ways. Curent research tends to indicate that the role of biological factors in the puerperium is unclear. One factor (premenstrual/menstrual complaints) however does seem to have some predictive value. Interpersonal relationships, social support and general stressful life events have been

demonstrated to be significantly associated with depression postpartum. Life events were more often associated with non-pregnant and pregnancy depressions than they were with postnatal depressions. Martin et al (1989) used the Life Events & Difficulties Schedule and found that women admitted with severe depression were twice as likely to have suffered a significant event as were puerperal controls. Seven of 8 women with prepartum depressions reported the depression was preceded by a severe event or major difficulty in the 38 weeks before onset compared with 9 out of 26 women who became depressed after childbirth. Thus social difficulties may be more important in prepartum than postpartum illnesses.Several studies also suggest that a number of psychological and social factors measured during pregnancy are predictive or associated with depression in the postpartum period. Past history of depression in self or family has been identified as a risk factor and an association with postpartum depression is consistently reported.

There have been few published reports of research based on a multidimensional model of postpartum depression. An international collaborative study of psychological adjustment in pregnancy and postpartum was carried out in Australia, the Netherlands and Italy (et al, 1989). The study aimed to identify factors contributing to a depressed mood postpartum and to determine the way in which these factors interact. The study also sought to establish the minimal risk of mood disorder for new mothers. Criteria were therefore selected in order to exclude women thought to be at higher risk (aged under 18 years, or over 40 years, single mothers, and those whose pregnancy was induced artificially, and immigrant women who were not fluent in the first language of the country concerned). The sample was obtained from women attending antenatal classes and outpatient clinics. The 329 women studied were in their first pregnancy to reach 28 weeks gestation. The study was prospective, with interviews and rating scales repeated at 28 weeks gestation, 4 days postpartum and 4 months postpartum. 293 women completed the study. A follow up study of the Australian cohort 3 years pospartum has also been carried out. Forty-three percent of women reported experiencing emotional problems in the 4 months after delivery. In 14% of the sample these problems lasted for more than four weeks. The major outcome assessment of mood was theBeck Depression Inventory (BDI). A multivariate analysis was utilized to identify the most important predictors of postnatal depression. The most important factor predicting depressive mood postpartum was the Beck Depression Inventory score during pregnancy. Those women who had the lowest depression scores, postnatally, had low BDI scores in pregnancy, were aged under 30, and had no past personal or family history of mood disorder. Those women with the highest BDI scores postnatally, had higher scores on the BDI during pregnancy, were aged over 30, had a past personal and/or family history of depression and continued to breast-feed until the fourth postpartum month. The continuation of breast-

feeding, age greater than 30 years, and prior history of mood disorder appeared to interact in a multiplicative way. Stress during pregnancy or delivery and a lack of support from the woman's parents, were factors which had an additive effect in predisposing the new mother to depression. Women who were older having their first baby and who had low symptom scores in pregnancy had a better mental health outcome if they lived in Italy. This reflected the greater family support received, particularly from the woman's mother.

A 3 year follow-up study of the Australian women in this prospective study found a significant positive relationship between Beck depression scores 3 years after delivery and Beck scores in pregnancy. These findings provide strong evidence that depression during pregnancy is a predisposing factor to later depression (Janson, 1991).

Kleivedra (1991) investigated factors associated with well-being in pregnancy and the postpartum using a prospective design studying 170 nulliparous Dutch women. Well-being and depression during pregnancy were related to self-esteem and the quality of the partner relationship. Postpartum well-being was strongly related to well being in pregnancy, but not to objective or subjective birth experiences, nor to whether the delivery occurred at home or in a hospital.

An anthropological critique (Stern & Kruckman, 1983) reviewed the cross-cutural literature on childbirth and identified the following components as supplying necessary & 14social support which may help cushion or prevent the experience of postpartum depression: structuring of a distinct pospartum time period; protective measures and rituals reflecting the presumed vulnerability of the new mother; social seclusion; mandated rest; assistance in tasks from relatives and/or midwife; social recognition through rituals, gift, of the new social status of the mother.

Proscriptions for behaviours in many cultures which allow the new mother to receive extra help from her family and to rest were described by Cox (1988). For example in Chinese society the mother avoids washing, does not go outside during the whole month, does not eat any raw or cold food, eats chicken, does not move around, does not go to another person's home, does Chinese woman the sanction to be idle in bed for an entire month. The question is whether such customs will help prevent postpartum depression. Jamaican women have a ritual seclusion for the first 9 nights and then spend the next 31 nights at home with the baby being looked after by the woman's own mother. In Nigeria the mother and baby are placed in a special hut within the family compound for 2-3 months, being cared for by the baby's grandmother. In contrast in Western society only vestigial remains of the 40 day lying in

period remain and there may be only limited support available. Rituals associated with childbirth are also less frequent than formerly, suggesting an ambivalence of society to the role of mothering. The lack of recognition, value and structured support may contribute to depression. Nevertheless a review of 202 traditional societies found that half of them expected a woman to return to full duties within 2 weeks of childbirth.

While postpartum depression has been identified as a common experience in Western countries, there have been fewer studies from other countries. A preliminary study (Shimizu & Kaplan, 1987) compared Japanese and US women. Women's role expectations and family relationships differ greatly for these 2 cultures. In Japan the 3 generational interdependence of parents and children together with the traditional stay of the new mother with her parents for a month after delivery provides the new mother with help and support. In contrast the nuclear family style of most Americans forces dependence on the husband-wife unit. Contrary to the investigator's hypothesis, there was no significant difference in depression between American and Japanese women. Furthermore, the isolation scores of Japanese and US women were similar. However step-wise multiple regression revealed that different variables were important in predicting depression for women of different cultures. Interestingly traditional role concept was the only factor predicting depression for Japanese women.

Cox (1983) reported his study of Ugandan women. 10% were found to have a depressive illness 3 months after delivery - similar frequency to that found in the Scottish study (13%). These findings suggest that postnatal depression is not confined to western societies and is not necessarily caused by the fragmentation of postpartum rituals. In Uganda "Amakiro" had long been recognized as a serious puerperal mental illness of the mother which might result in death.

Further research into postnatal depression in different cultures is needed, including an assessment of the degree of support received by women and whether postnatal rituals were observed.

Summary

There is increased recognition that many women suffer from postpartum depression. In addition to the personal distress suffered, this disorder causes marital disharmony, interferes with the woman's attachment to her child and may lead to child abuse. If untreated, depression may persist. The aetiology is not clear, but is thought to reflect an increase in

physiological vulnerability in combination with other factors - biological, psychological and social.

As many of the determining and risk factors can be identified, there is the possibility of intervening in order to maximize postpartum psychological adjustment. Possible interventions for the mother at risk include psychological and/or social techniques such as increased social support and marital counselling. Evaluation of these interventions is needed. Increased recognition and earlier treatment is needed to help promote mental health and prevent sequelae both for the woman and her family.

Mother-infant relationship

Current figures suggest that at least 1 in 10 babies born will be cared for over the first 6 to 9 months by a mother passing into and usually through a bout of clinically significant depression. There is concern (see Editorial, 1989) about the long term effects of a temporarily depressed maternal psychiatric state on the development of the child. These could persist in various elements, including language development and cognitive functioning. Further, the links between postnatal depression and other factors such as the quality fo the relationship between the mother and her child may also impact on the child's development. Research has shown 2 to 3 months old babies to be sensitive to and discriminatory of the quality of maternal behaviour and that inappropriate maternal behaviour elicits signs of distress in the infant which then shows signs of withdrawal. Coghill et al (1986) found lower scores in the general cognitive index for children of mothers who had experienced a period of depression in the child's first year. The Australian prospective study (Janson, 1991) did not find a relationship between depression (BDI Scores) and child's cognitive development. Independent reports of child behaviour disturbance by both mothers and fathers correlated significantly with maternal depression scores. Maternal depression may be more likely to impact on child's behaviour than on cognitive functioning. More studies are needed although there are many methodological problems inherent in this type of research.

Mother-infant interaction disorders may or may not coexist with psychiatric illness such as depression.

These disorders may be classified as follows (see Kumar & Brockington, 1988) :

1. Delayed Attachment (1/10 births).
   Some mothers experience delay in the development of affectionate feelings for theinfants. This may or may not be associated with depression.

2. Obsessional Thoughts of Hostility to the Infant (1/100 births).
   Intrusive and distressing thoughts about the baby including impulses to inflict bodily harm may co-exist with a normal mother-infant relationship.

3. Rejection of the Infant (1/100 births).
   In this condition there is lack of feeling for the infant, persistent hostility and a determined effort to avoid the maternal role.

4. Child Abuse and Neglect (1/1000 births).
   This may occur outside the context of severe mental illness. Abuse may occur in a setting of impulsive violence on the part of an inadequate or unsupported parent. There may be a history of familial violence, marital disharmony, lack of kinship support or isolation, low self-esteem, poor models for motherhood and lack of maternal skills.

5. Infanticide (1/50000 births).
   a) Neonacticide, the murder of the child within 24 hours of birth (mothers usually under 25, unmarried, without evidence of depression or psychosis or suicidal behaviour. Child unwanted and mother fearful of reaction of families to pregnancy).

   b) Filicide is murder of child more than 24 hours after birth and is usually associated with mental illness. There may be associated suicidal behaviour, acute psychosis, and/or ideas of the necessity to relieve real or imagined suffering. Some babies are killed as consequence of child abuse, others in revenge against a husband.

Pregnancy Loss

Although grief has been understood and documented for many decades, only recently have the full impact and consequences of pregnancy loss become appreciated. Unique aspects of pregnancy losses surrounding miscarriage and ectopic pregnancy, stillbirth or neonatal death include : real (actual) loss of a person; threatened or impending loss of a person; loss

of status (motherhood); and symbolic loss (of the future). In addition there is a crucial loss of self-esteem resulting from the woman's inability to rely on her body and give birth. For postneonatal loss, numerous social institutions support the bereavement process. Social rituals have not yet been accorded to pregnancy loss "celebrated only in the tears of women" (Friedman & Cohen, 1982). Emotional shock, feelings of loss, sadness, emptiness, anger, inadequacy, blame and jealousy. The final stage of the mourning process is characterized by a diminution of feelings of self-reproach, loneliness and emptiness (Woods & Esposito, 1987).

Despite the large proportion of pregnancies which end in miscarriage (between 15-20% of pregnancies), there has been a seeming inattention by health care professions to this distressing experience (Reinharz, 1988). The lack of sympathy for a woman who has miscarried has been evidenced by societies past and present. In the Middle Ages, women were sometimes burned alive after miscarrying. In some societies repeated miscarriage represents grounds on which a man may divorce his wife. Reinharz (1988) relates the invisibility of miscarriage amongst other reproductive concerns for women to a general fear of death in our society and Western society's obsession with success and discomfort with failure. Although the prevailing view of the medical profession is that the trauma is not great (Reinharz, 1988), miscarriage is experienced as a loss by most women and is therefore likely to be stressful. Losses involved include those of : this particular pregnancy; a sense of control about life, health or fate. Lack of community support and rituals deny women comfort and lead to feelings of isolation.

Early pregnancy loss may mean that there is no recognizable body to visualize, and this further complicates the mourning process. Borg & Lasker (1981) suggest that doctors should meet several times with couples who have suffered miscarriage, to provide information and an apportunity to address questions. Mothers of babies whohave died should not be placed in maternity wards, visiting hours should be unrestricted and funeral/burials should be offered. Social support and community support may positively influence the woman's adjustment to miscarriage.

There is a growing literature on the long term psychological effects of stillbirth and neonatal death. Longer term sequelae of continuing psychological symptoms and disturbed family relationships have been reported by a number of authors. Symptoms suffered by families include depression, sleep disturbances, social withdrawal, anger, guilt and marital disturbance (Dyergrove & Matthieson, 1987; Vance et al, 1991). Mothers have more symptoms than fathers, and parents affected by Sudden Infant Death Syndrome have the most

symptoms of anxiety and depression (Vance et al, 1991). Studies have identified the following factors as influencing the progress and severity of mourning: lack of parental support (Tudehope et al, 1986); lack of contact with the ill or dead infant (Tudehope et al, 1986); length of time the child lived (Dyregrove & Matthieson, 1987); communication between parents (Laroche et al, 1984); reaction of hospital staff and hospital practices (Laroche et al, 1984); and time since the death (Murray & Callon, 1988).

7.3 Menstrual Cycle Linked

Of particular importance when examining women's mental health is menstruation (O'Rourke, 1984). This biological phenomenon has been the subject of myths and taboos within and among various cultures. These myths distort the reality surrounding menstruation and create ambivalent feelings about the value and usefulness of this function outside of its necessity as a means of reproduction. Thus studies concerning menstruation need to take into account cultural and psychosocial factors that define the meaning, values and behaviour associated with this biological phenomenon. Research on the biopsychosocial aspects of menstruation may help explain psychological well-being in women, exacerbation of psychological distress, choices of contraception, the interrelationship of belief systems and health behaviour. For the female menstruation is a major life event.

O'Rourke (1983) studied factors affecting the well-being of 633 healthy employees aged between 21 and 44. Demographic factors (age, ethnicity, income) and perceived general health status significantly affected perceived general well-being. The number of premenstrual and menstrual symptoms also significantly affected personal well-being as did the type of symptoms. The symptoms of negative affect and arousal accounted for most of the effect. Specific menstrual symptoms did not adversely affect personal well-being suggesting a greater acceptance of menstrual rather than premenstrual symptoms.

Mood and behavioural changes have been observed to be associated with the menstrual cycle since ancient times. Most women are probably aware of cyclical changes in mood and behaviour. The findings of 24 prospective studies of affective fluctuations during the menstrual cycle were summarized in an earlier review (Dennerstein & Burrows, 1979). The majority of studies reported negative moods characterized by irritability, restlessness, anxiety, tension, migraine, sleep disturbance, impaired concentration, depression occurred more frequently during the premenstrual and menstrual weeks. Although positive moods were not assessed as frequently as negative moods, the review found that increased feelings

of well-being, elation, pleasantness and activation occurred during follicular and mid-cycle phases. From a variety of studies the incidence of premenstrual symptoms ranged from 25%-96% depending on the criteria, timing, type of measurements and charactersistic of the women studied. The incidence rates of premenstrual symptoms amongst general practice attenders in Britain were reported as varying from 25% (Kessel & Coppen, 1963) to 75% (Clare, 1977); factory workers in the USA - 36% (Bickers & Woods, 1951); hospital personnel and students in the United Kingdom 33% (Sutherland & Stewart, 1965); wives of American university graduates 52% (Moos, 1969); and French women in a community sample 64% (van Keep & Lehert, 1981).

Janiger et al (1972) compared symptoms experienced by women in Athens, Tokyo, Istanbul, northern Nigeria, with Apache Indian women and Californian women. There are a number of methodological problems as the study was based on retrospective recall and the groups were not strictly comparable. For example, the samples varied from students to outpatients. Premenstrual symptoms were found in all cultures examined. Several symptoms showed marked variations in frequency between the various cultural groups. For example there was a paucity of breast complaints among the Japanese, but a high incidence of headache symptoms in the Nigerian group.

Japanese had fewer symptoms than the other groups, with American women intermediate, and Turkish and Nigerian women showing the highest incidence and symptom scores. Thus symptoms suggestive of premenstrual distress are present in diverse cultural groups but are subject to individual variation in the incidence, nature and severity of symptoms.

Hasin et al (1988) compared menstrual and premenstrual symptoms, but the percentage varied from 88.5% for Greek women to only 42% for Vietnamese women. Turkish, Greek and Vietnamese women complained mainly of somatic symptoms, while 60% of the Australian and 53% of the Italian women's complaints were of psychological and behavioural symptoms. Symptoms were evaluated as significantly more severe by the Greek women and significantly less severe by the Vietnamese and behavioural symptoms. Symptoms were evaluated as significantly more severe by the Greek women and significantly less severe by the Vietnamese women. More research is needed to identify whether the differences observed between the ethnic groups are due to physiological changes in the cycle (longer cycles in the Vietnamese and shorter cycles in the Turkish women) or represent psychosocial differences between the ethnic groups.

Vallings (1987) in a retrospective study, compared premenstrual symptom experience of

Maori, Polynesian and Pakeha women attending an Auckland family planning clinic. Severe symptoms were more likely in both Maori and Pakeha women to be experienced by nonhormonal contraceptive users. The symptoms reported were similar in all groups studied. The most severely rated symptoms were depression and headache. Most frequently reported symptoms were tension; irritability; depression; fluid retention; breast tenderness and headaches. 11% of Maoris, 14% of Polynesians and 18% of Europeans rated at least some of their symptoms as severe. When asked how they coped with premenstrual symptoms most of the Maori and Polynesian women answered : "more rest"; "eating watercress"; "extended family help" whereas the European women were more inclined to read books and attend courses on premenstrual syndrome. This small study found that premenstrual symptoms did appear to occur across all groups. A greater number of Polynesian women experienced no symptoms at all (29%). European women showed the greatest incidence of symptoms (84%), the highest incidence of severe symptoms (18%) and considered such symptoms as problems whereas the Maori and Polynesian women were more accepting of their lot and did not really expect any advice or treatment.

In a World Health Organization study (Snowden & Christian, 1981), the incidence of negative mood changes varied from 38%-71% across different cultures. Mood changes were more noticeable in the women of the United Kingdom (71%) reference group. About 60% of the women claimed to have physical discomfort prior to or during menstruation with no significant cultural topology. These findings may indicate that cultural relativity may affect the perception of symptoms and determine what is regarded as important and acceptable.

An outstanding feature of many of these studies is that though large proportions of women report symptom experiences, the actual number who find these changes problematic and seek treatment is much smaller. It is not clear whether treatment seekers experience a greater magnitude of symptoms than does the wider population; or whether treatment seekers may be women who give more serious attention and meaning to cyclic changes than do others (Renaer, 1983).

The combination of affective, behavioural, cognitive and physical changes occurring premenstrually have been designated as a syndrome - the premenstrual tension syndrome (PMS). PMS research in the past has suffered from the failure to adequately define this syndrome with an overinclusion of symptoms without due regard for the cycle phase in which symptoms appear. This led to difficulties in the comparison of findings and has also contributed to the appearance of separate methodologies that compounded the problem. Recognition of the need to reach consensus on the features of this disorder led to the

American Psychiatric Association including PMS as a special category disorder called Periluteal Phase Dysphoric Disorder (PPDD) in the appendix of the revised edition of the Diagnostic and Statistical Manual (DSM-IIIR, 1987). Diagnostic criteria included a history of multiple symptoms (in most menstrual cycles) in the premenstrual week, with relief from symptoms by the week postmenstruation. The symptoms had to be severe enough to cause marked distress or interfere with social or occupational functioning and temporal linkage of symptoms to the premenstrual phase of the cycle had to be confirmed by prospective daily-ratings of at least two cycles. The contemporary use of clearly defined diagnostic symptoms linked to specific cycle phases has resulted in more parsimonious estimates of PMS prevalence, of approximately 5% of women of reproductive age (Clare, 1985).

There appears to be a clear hormonal basis at the premenstrum for breast swelling and nipple sensitivity, water fluid redistribution and diuresis, alterations to specific categories of efficient behavioural and cognitive abilities (Philips & Sherwin, 1991) and some cyclic changes in mood and sexual responsivity. All of these changes occur in non-treatment seeking women. In treatment seeking PMS sufferers, these changes are reported to occur at magnified levels.

Some endocrine abnormality has long been sought to explain why some women are more severely affected than others. Despite a plethora of studies, there has been a failure to confirm any oestrogen progesterone imbalance amongst PMS sufferers. A number of studies have nevertheless demonstrated that PMS is confined to ovulatory cycles, and the cyclical symptoms are removed by medical or surgical oophorectomy (Casson et al, 199) but not by hysterectomy (Backstrom et al, 1981). Other biological theories, such as that of nutritional inadequacies, have failed to be supported by recent research. Still other biological theories related to neurotransmitters and neurohormones
are still under investigation. Theories of specific personality factors, sex-role conflicts and conditioned learning have been widely reported. An interactive bio-psychosocial approach is proposed and has been detailed in section 6 of this report.

The relationship between the menstrual cycle and psychological morbidity is likely to be complex. Menstrual cycle changes may exacerbate existing psychiatric disorders. Janowsky et al (1969) noted a significant increase of psychiatric admissions during the premenstrual and menstrual phases. Abramowitz et al (1982) found that 69% of depressed patients were admitted during the eight paramenstrual days ($p<0.001$). Thirty-seven percent of schizophrenic patients were admitted during the paramenstruum ($p<0.06$). Research of the relationship between suicide and the paramenstruum have yielded less consistent results (Wetzel et al, 1971).

Gath et al (1980) found that psychiatric symptoms were significantly more common among women complaining of premenstrual tension, dysmenorrhoea, heavy periods and flushes and sweats than among women complaining of other gynaecological symptoms. It is unclear from this type of study whether psychiatric symptoms are primary or secondary to the gynaecological complaints.

However, the two longitudinal studies reviewed in the next section present evidence suggesting that psychological morbidity is more likely to be a sequelae than antecedent to certain menstrual and gynaecological complaints (Slade & Anderton, 1991; Treloar et al, 1991).

7.4 Hysterectomy

Gynaecological surgery poses a unique stress for women because of the identification of the reproductive organs both with sexuality and with the wider concept of feminine identity. This stress is particularly apparent when one considers hysterectomy. Of major concern has been the high incidence of this operation in many Western countries sand a long-reputed association with psychological and sexual sequelae.

Several investigators reported that hysterectomy was associated with adverse psychological sequelae as evidenced by an increasing incidence of psychiatric referral (Barker, 1968) and an increased frequency of treatment with antidepressants in a general practice setting (Richards 1973,1974). These findings from retrospective studies have not been confirmed by the more recent prospective studies, which have highlighted a previously unrecognized strong association between premorbid psychological dysfunction and hysterectomy.

The prospective studies of women undergoing hysterectomy by Martin et al (1977, 1980) in the USA, Gath et al (1982) in the United Kingdom, Ryan et al (1989) in Australia, are of considerable interest. These studies utilized structured psychiatric interviews and psychological rating scales pre- and post- operatively. Before operation these studies reported a similar and high prevalence of pre-operative psychiatric morbidity (55%-58%). The type of diagnosis varied. In the US study of Martin et al (1977), there was a 27% incidence of Briquet's syndrome (a somatising disorder) and a 30% prevalence of depression. The UK and Australian studies found that of those diagnosed on the PSE as having a psychiatric disorder, around 61% were depressed and the remainder suffered from anxiety states. The outcomes also differed. The US study did not demonstrate any reduction in psychiatric morbidity after

surgery. This would be consistent with the high incidence of somatization disorder in the USA sample. The UK and Australian studies found a marked diminution in psychiatric morbidity at long term follow-up, 14 to 18 months later. There was a marked improvement in general well-being in the UK and Australian studies, where at long term follow up, up to 84% reported their general health to be better. The post-operative prevalence of psychiatric disorder in the Australian sample was 32%, which compares with a community prevalence rate for Australian women of 15% (Henderson et al, 1981). There was no evidence that hysterectomy led to greater psychological distress. There were few women who developed new psychiatric syndromes which had not been present pre-operatively. In the Australian study, each of the three women concerned related significant life events which had occurred in the intervening period to their current depressive mood. The principal risk factors of poor psychological outcome were the previous psychological morbidity as evidenced by mental status and personality inventory scores. The Australian study found that involvement in the research process did not affect the psychological outcome but did affect the sexual adjustment achieved. This study (Ryan, 1985) provided good evidence that even the minimal intervention of a pre-operative research-based interview couldpositively enhance sexual outcome.

What remains unclear from the above prospective research, are the reasons for the high prevalence of psychological dysfunction in women who are scheduled for hysterectomy. Gynaecology populations have been shown in many studies to contain a high incidence of women with, or at risk of, psychiatric disorder. Gath et al (1987) found a strong relationship between gynaecological and psychiatric symptoms in a community sample of middle aged women. These authors suggested that either gynaecological symptoms may produce psychiatric symptoms in a vulnerable population or alternatively psychiatric disturbance may reduce tolerance of minor physical changes. In a study of 81 consecutive gynaecology admissions for a variety of elective surgery, Hrasky and Morris (1986) found a minimum prevalence rate of psychiatric caseness using the present state examination of 37%. This rate is more than double the prevalence rate for women in Australian community samples but not as high as the rate for a hysterectomy sample.

In a longitudinal study of the relationship between gynecological symptoms and psychological distress, Slade and Anderton (1991) found that emotional symptoms in gynaecological outpatients rapidly reduce to normal levels after consultation and that persisting anxiety symptoms are related to gynaecological outcome. Chronic gynaecological symptoms maylead to an increase in depressive symptoms. These findings are in keeping with those from a longitudinal study of twin pairs in Australia (Treloar et al, 1991). 3,808 twin pairs were surveyed in 1980 - 1982 and again in 1988 - 1990. New hysterectomies performed in the

intervening time interval were predicted by genetic factors (66% of the variance). How much of the genetic variance in hysterectomy is due to the genetics of menstrual dysfunction needs to be established. Risk factors for later hysterectomy from the earlier survey data included reports of : degree of limitation associated with menstrual periods, number of days of menstrual bleeding, menstrual pain, total period of oral contraceptive use and (retrospectively reported) interference by premenstrual symptoms in usual activities. None of the psychological variables scored in the earlier survey were predictive of later hysterectomy. These variables included : anxiety index, depression index, extroversion and neuroticism scores, life events, experience of rape or sexual assault.

In summary these findings suggest that chronic gynaecological symptoms lead to psychological distress and disorders and to hysterectomy. There is a marked reduction in psychological symptoms following improvement in gynaecological complaints. Counselling is needed to ensure optimal sexual outcome for women undergoing hysterectomy.

7.5 Menopause

Women naturally cease menstruation between the ages of 50 and 52 years on average in Caucasian populations. As overall life expectancy now approaches 80 years in Western countries, women can expect to live more than a third of their lives beyond menopause. The relationship of psychological symptoms to the occurrence of menopause has been controversial. Gynaecologists have concentrated on determining which symptoms can truly be attributed to an estrogen-deficient state and are thus amenable to hormone replacement therapy. Social scientists have maintained the view that the symptomatology of midlife is more affected by the expectations of a particular sociocultural group or by other factors such as life stress. Women in their middle years experience a great deal of personal change or major life events. It is usually assumed that these are negative: such events include onset of a major illness in self or spouse or close relative, death of spouse or close relative, midlife crisis of spouse or retirement, own retirement, employment uncertainty, care-giving to frailolder parent, children leaving or returning home. Others such as Ballinger (1979) refer to the positive counterbalances such as arrival of grandchildren, freedom from unwanted conception, and the opportunity (with freedom from the nurturing role) to purse other activities or plans.

McKinlay (1989) in a community-based prospective study of 2,300 premenopausal Boston women, found that the overwhelming majority of women report positive or neutral feelings

concerning cessation of menses and the shift in attitudes is towards positive or neutral feelings as women experience menopause. The percentage of women reporting relief was just slightly higher than that found in a Japanese sample (Lock, 1986). The cessation of menses had almost no impact on subsequent perceived health, physical or mental. The one major exception is the surgical menopause group which exhibits poorer health and higher use of health services before the surgery as well as subsequently. Current health status was consistently explained by prior health status (65-80% of explained variance). Small independent contributions were also made by education, employment and marital status. Becoming unemployed recently was associated with increased subsequent ill-health.

Negative attitudes towards menopause were related to general symptom reporting and depression. Additionally negative attitudes prior to menopause were related to subsequent symptom reporting during menopause. Educated women had somewhat more positive attitudes. Employment, better health and education were associated with agreement with the statement that women with interests hardly notice the menopause (Avis & McKinlay, 1991). These findings are in agreement with considerable social psychological research which has demonstrated that a person's behavior can be affected by his or her expectations.

In order to determine whether the frequency of depression was increased around the menopause, Winokur (1973) studied psychiatric admissions. He found no significantly greater risk of developing depression at the menopause when compared with other phases. High rates of depression are found amongst women attending menopause clinics and middle aged women attending gynaecology clinics. However psychiatric symptoms are increased among all hospital outpatients. Four general population samples in Sweden, England, USA and Canada did not find an increase in depressive disorder at the menopause.

In the Boston study (McKinlay, 1989), those with a recent surgical menopause were the most depressed group. When this group were removed, factors contributing to depression were : previous poor health status, women reporting at least two physical symptoms, worry caused by a family member and sociodemographic factors. Women with a lower education level, and who were widowed, separated or divorced had a depression rate more than twice that of college educated women of the same marital status. There was a low rate of depression for never married women.

Further, in refute of the empty nest syndrome, women with children at home for a longer period or whose children had returned home, were more likely to report stress than those with no children at home. Stress was also reported by those who cared for a parent whether or

not the parent lived in the home. Work may alleviate the stress of nurturing roles and thus help prevent morbidity. Work, with its clear expectations, may provide a sense of satisfaction and self-worth not equalled by the familial nurturing roles, for which expectations are implicit and more ambiguous. Current employment served to substantially reduce the impact of other roles and accompanying stress on health and utilisation behaviour - thus work outside the home appears to play a protective effect on health in the midlife years.

Cooke (1984) studied a population of Scottish women. Menopausal status was enquired about as well as chronologic age. They found that the severity of psychologic complaints began to rise in the late 30s, reaching a peak in the early 40s, and began to decline in the late 40s. Cooke found an increase in life events during the climacteric years. Cooke also found that nonexit stress was associated with mood complaints (such as depression, crying spells, panic attacks, and worrying), whereas exit stress was not. Both exit and nonexit stress were required to produce elevation in "somatic" symptoms (faintness and dizziness, headaches, and tingling or numbness in the body). Using a hierarchical regression analysis, Cooke found that the loss of one's mother before the age 11 and employment status act as vulnerability factors for life event stress, influencing the occurrence of mood complaints. The degree of involvement with children was directly associated with the occurrence of psychologic complaints. The number of confidants available to the patient was directly associated with the lessening of psychologic symptomatology and had a synergistic effect with life event stress.

Thus the availability of confidants may help to diffuse life stress. Neither the level of confiding in the spouse, the number of children at home, nor the quality of communication with the children had any effect. Similar results were found for the "somatic" complaints, except that the degree of involvement with the children no longer had any effect. Van Keep (1983) reported that women who were well-integrated into their environment and surrounded by friends reported fewer climacteric symptoms than those who were lonely.

Hunter and co-workers (1986) used a multiple regression analysis to determine which of the following background factors were associated with the presence of symptoms: menopausal status, age, current illness, marital status, social class, and employment status. Vasomotor symptoms and sexual problems were best predicted by menopausal status alone. Menopause status was also a strong predictor of depressed mood. Lower social class also predicted depressed mood, anxiety/fears, cognitive difficulties, sleep problems, and somatic symptoms. Absence of employment was a predictor of somatic symptoms and anxiety symptoms.

Depression in the menopausal years may be associated with feeling that the menopause means loss or fertility and/or femininity. Such reactions are uncommon in Western societies. The research findings summarized above suggest that depressive disorder and depressed mood may relate more to the vicissitudes of life than to the menopause per se.

Changes in mood are sometimes claimed to be secondary manifestations of disabling vasomotor symptoms such as hot flushes and sweating. The vasomotor symptoms and those of atrophic vaginitis are held by some to be the only true symptoms of ovarian failure (Utian, 1972). Psychologic complaints are then explained by a "Domino Theory". That is, if the flushed cause the woman to stay awake and the night sweats cause her to change the bed linen, she will report insomnia and fatigue, which may lead to irritability and nervousness.

A number of the studies reviewed have reported a peaking of depression symptoms in the immediate premenopausal years (McKinlay, 1989; Cooke, 1984). These findings suggest of hot flushes, and analysis was made of the 20 patients who had not reported hot flushes. Vaginal dryness, poor memory, anxiety, and worry about age and self continued to be significantly improved by estrogens, indicating a direct positive effect of estrogen on some aspects of mental status.

Underlying endocrinological changes, which begin some years prior to menopause, may affect mood, although this effect seems to be temporary. Evidence of the specific effects of steriod hormones on mood derives largely from clinical trials. Both the two largest double-blind, placebo-controlled, cross-over studies that have been published report improvements with estrogen therapy over placebo for a variety of psychologic symptoms. Campbell and Whitehead (1977) compared two months therapy of 1.25 mg conjugated estrogens (daily) with placebo in a short-term cross-over involving 64 patients with severe symptoms. Estrogen was found to be significantly more effective than placebo in alleviating 12 symptoms (hot flushes, insomnia, vaginal dryness, irritability, poor memory, anxiety, worry about age, headaches, worry about self, urinary frequency, optimism, good spirits) and produced increased coital statisfaction. In order to determine whether this improvement reflected relief

The other large double-blind, placebo-controlled cross-over study, Dennerstein et al (1979, 1980) also found a beneficial effect of estrogen on mood. However all the 49 women had undergone hysterectomy with bilateral oophorectomy. This study set out to measure the effects separately of an estrogen and a progestin and compare these with placebo. The study used a cross-over design. Ethinyl estradiol given alone was found to have the most beneficial effect on mood as measured by Hamilton Depression Rating Scale scores and interview

ratings of general well-being, depression, fatigue, anxiety, irritability and insomnia. This study also found that ethinyl estradiol had a beneficial effect on female sexual desire, enjoyment, and vaginal lubrication (all measured by ordinal scales) and on orgasmic frequency (recorded daily). There was a trend toward norgestrel being more inhibitory. The combination pill was less beneficial than estrogen alone. Finally, when the relationship between headaches and the administration of hormones was examined, it was found that an increase in headaches occurred when therapy was changed from estrogen-containing compounds to the nonestrogens (norgestrel or placebo) (Dennerstein et al, 1978). It is not possible to extrapolate from these treatment studies to the community-based studies. Longitudinal community-based studies will provide needed information on the risk of hormone therapy for perinatal mood changes.

Cross-cultural Differences

Menopause is a complex transition involving biological psychological, sociological and cultural variables. Menopause should be viewed as a process and not an event, as something which is shaped by historical factors and environmental and cultural context, and by each individual's personal history, both biological and social. In this life cycle transition powerful symbolic meanings (individual and social) are attached. The menopause is not merely the end of menstruation, nor even an inevitable part of aging; it also leads to a moral discourse in which ideas about gender and especially the roles of middle aged women are raised (Lock, 1991).

Griffen (1977) reviewed the Human Relations Area Files in order to find documentation for different customs relating to menopause in differing cultures. In eight cultures it was specifically noted that no behaviour changed for menopausal women. Changed behaviour did occur in some cultures. For example elderly Tiv women put on the snail shell as an insignia that they are not longer sexually available and return to live with brothers. The rural Irish believe that menopause can induce insanity and at least 3 contemporary Irish women confined themselves to bed from their mid-40s until death some years later. In two African cultures menopause was viewed as disorder. For example a Youruba woman believes that cessation of menses is a pregnancy prevented by witchcraft from terminating normally. In other cultures menopause results in greater freedom for women. Women are then able to eat foods previously forbidden or to get drunk or indulge in other behaviours, such as appearing at public dinners normally only attended by men. In China after reaching 60 years, women were released from male domination. In New World cultures menopause signalled accession

to increased social and sometimes supernatural power. Thus the loss or roles of reproducer - mother - wife signalled access to role of curer. Thus the behaviour of any female is a product of the interplay between her unique biological heritage, her shared sociocultural environment and the choices she as an individual makes from among the alternatives available to her in her culture.

Some apparently contradictory results are beginning to emerge from cross-cultural research. Among Mayan Indians, north African residents of Israel, the Rajput of India and Japanese theoccurrence of somatic symptoms is either low or absent. In contrast studies in North America and Europe, Zimbabwe and Varanasi, India, elicited much higher somatic symptom reporting. It is unclear whether these findings represent real differences or merely reflect artifacts of research design and methodology. Lock believes there are probably some differences, both biological and socio-cultural, but also that some of the reported variations may indeed reflect poor research design. Intensive small group interviews have revealed that the meaning of menopause is subject to a wide degree of interpretation and may not coincide with the norm of that society. Also in societies where women have numerous births and long periods of amenorrhoea it is extremely difficult to assess the onset of the menopause.

Lock (1986) found that menopause is regarded as a natural life-cycle transition in Japan in which the biological marker of cessation of menstruation is not considered to be of great importance. Symptom reporting is low regardless of menopausal status. Symptoms such as hot flushes and sweats are lower (12.6% of perimenopausal women) than from other areas. Shoulder stiffness,while frequently reported (54.8% of perimenopausal women), is not linked to menopausal status.

Feelings of depression and melancholy were low but significantly higher in the premenopause than peri and postmenopausal groups. Changing family norms in this and other societies means that the present generation of women entering their fifties are the first where the majority must face later life in a nuclear family. What was apparent in the minds of most of the informants was how they would get on, living by themselves with husbands whom they may never have come to know very well given the organisation of contemporary Japanese life.

There are obviously many problems in such cross-cultural research. These include possible bias introduced by the investigators, language problems, and the possibility that some cultures express emotional changes in masked ways.

No studies appear to have compared the endocrine status of women from different cultures, on the presumption that the duration and severity of endocrine changes are similar in different cultures. This may not be the case. Surprisingly little is known of the relationship of genetics,the environment and diet to circulating and stored estrogen nor about the interrelationship of psychosocial variables, estrogen nor about the interrelationship of psychosocial variables, estrogen levels and the objective measurement or the subjective experience of menopausal symptoms. Nevertheless, there is evidence to suggest that cultural factors may be important in determining a woman's response to biologic changes and the expression of perceived changes.

7.6 Mental Health of Aging Women

The problems of old age are largely the problems of women. In Western societies at the age of 75 years, most women are widowed. Large numbers live alone often without a network of available family resources. For every 100 women aged 80 and over in Australia, there are only 47 men (Kane, 1991). Research in several countries suggests that a large proportion of the longer life span women can expect is actually spent in pain and ill-health (Kane, 1991). The increase in the aging population has profound political, and economic implications as this group has greater needs for health care, social welfare and economic support. Only a small segment of the elderly (5%) are institutionalized. Of the 5% living in nursing homes 3/4 are women. Thus it is a myth that theelderly are a helpless, disease ridden group. Negative images of the elderly woman as unattractive, dependent, and physically ill have significant psychological and social repercussions.

Russo (1990) in her review noted that 25% of persons over 85 years of age have Alzheimer's disease or a related disorder, and most are women. There must also be concern for the well-being of those who care for them. In the USA, 72% of the 2.2 million people caring for the elderly without pay are women. In a review of recent research, Morris et al (1991) showed that the demands of the care-giving role are experienced differently by men and women. Both the subjective and objective strain appear to be greater in female carers of dementia sufferers. Factors that influence this include differences in role expectations and coping strategies.

Women account for more than 70% of the chronically mentally ill in nursing homes, and family support systems for these women may be virtually nonexistent. Elderly women are amongst

the poorest of the US population. Major diagnoses are depression, organic brain syndromes and the dementias. Depression is the single most pressing problem affecting elderly women's mental health. Older women are also vulnerable to alcohol and drug abuse particularly those : isolated and depressed women living alone; women trapped in unhappy marriages; those institutionalized in nursing homes or psychiatric settings; those culturally isolated; and those lacking the resources to enter treatment programmes. Anxiety is another common problem for elderly women and social and economic factors are the primary contributing factors. Yet older women are often underepresented in the use of mental health services. There is also concern about the use of psychotropic drugs in elderly women because of harmful side effects and drug interactions.

For women the emotional quality of their social activities and the degree of satisfaction with social relationships are the important predictors of morale (McCallum). Psychological well-being has been found to be predictive of morbidity, mortality and institutionalisation in the elderly. McElmurry & LiBruzzi (1986) report that the older woman without a connection to others and social activities is at risk for emotional discomfort. Well-being in old age is associated in a cumulative way with the amount of expressive social supports and their range. These relationships provide acceptance, reassurance of worth and participation in leisure activities (Mugford & Gibson).

8. SUMMARY

Both community-based studies and studies of treatment seekers indicate that women are disproportionately affected by mental health problems and that their vulnerability is closely associated with marital status, work and roles in society.

Women's mental health cannot be considered in isolation from social, political and economic issues. When women's position in society is examined, it is clear that there are sufficient causes in current social arrangements to account for the surfeit of depression and anxiety experienced by women. Women experience and respond to stress quite differently than do men. In addition, the routine of women's lives render them at risk to experience more stress than do men. This reflects the greater number of social roles women fill as wife, mother, daughter,employee and carer of others. Beyond that, women's reproductive role of bearer, producer, feeder and nurturer of children produces unique potential for stress related effects.

Thus, the well-documented higher morbidity in women's health across the lifespan has a

clear biosocial underpinning to explain the burnout rates. It is not surprising that the health of so many women is compromised from time to time. Rather, what is more surprising is that stress - related health problems do not seriously affect more women.

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TABLE 1

ECONOMIC	PHYSICAL	PSYCHOLOGICAL	MARITAL	SOCIETAL
extra financial demands	sleep deprivation	new skills required	no partner	myths of mother-hood as 'bliss'
	excess work	multi-channel focussing	works long hours	expectations of the good mother
	demands -overoad -simultaneous (over exten-sion)	feeling overwhelmed	low support to wife	
	boring repe-titive tasks	feeling loss of control, disempowered		
	adverse work conditions	loneliness		
		increased responsibili-ties		
		no tangible rewards		
		low adult contact		
		loss of identity		
		isolation, social deprivation		
		unrealised expectations		
		no/little experience in child care		
		unpredictability of tasks		
		unrealistic expectations		
		no relief/breaks/ personal space		